TITLE The Health of Nations: Public Health and the Social Reproduction of the Working Class in Canada and Britain 1900-20

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Public Health and the Social Reproduction of the Working Class in Canada and Britain 1900-20

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SUMMARY

The first two decades of the twentieth century saw a dramatic period of innovation and expansion in public health programmes in Britain and Canada. This thesis argues that this period of growth and change in public health was one aspect of a major reorientation of social policy.

This reorientation had two major features. First, the national working classes of Britain, Canada and other countries were increasingly delimited through immigration controls and similar means of regulating international mobility. Secondly, new social programmes were developed which attempted to improve the physical, mental and moral condition of these delimited working classes, on the basis that their well-being was the foundation of national productivity.

Public health played a major role in both the delimitation and improvement of national working classes. In Canada, the first major programme of immigration controls was introduced in this period, centering around the selection or rejection of immigrants on the basis of medical inspection conducted according to public health criteria. In both Britain and Canada, new public health programmes were developed which aimed to improve the condition of the working class. This was to be accomplished primarily through home visiting programmes which attempted through education and inspection to establish standards for the domestic labour of women as mothers and home-makers.

This thesis examines the contribution of public health to this reorientation of social policy primarily through the analysis of the theoretical work of key policy-makers as reported in professional journals and government documents. These officials displayed a keen sociological understanding of the broader significance of their activities in the development of a productive national working class prepared for work or war. Indeed, they understood clearly that the health of nations is an important basis of the wealth of nations.

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Chapter 1
INTRODUCTION: PUBLIC HEALTH AND SOCIAL REPRODUCTION

1.1 The Public Health Moment 1900-20

The first two decades of the twentieth century were in many ways the high water mark for public health as an approach to social policy and health care. Public health was on the leading edge of social policy, defining and attempting to solve a new set of social and political problems. It was at the centre of state medicine, on the front line in the battle to prevent and treat such conditions as tuberculosis, infant mortality, mental handicap and sexually transmitted diseases. A substantial social and moral reform movement placed public health at the top of their agenda.

Public health officials felt that they were participating in a substantial breakthrough which would vastly expand the parameters of their activity and dramatically improve its effectiveness. The old sanitarian public health of the nineteenth century was being replaced by a more scientific method, the new hygiene based on germ theory. The old sanitarianism had connected the spread of disease to smelly atmospheres, and so had concentrated on improving ventilation, sewer systems and water supplies through engineering the urban environment. The new hygiene sought to eliminate routes of germ transmission through changing habits and attitudes, emphasising particularly cleanliness and sound management in the home.

The new hygiene was seen as the basis of a breakthrough that could make public health the definitive form of health and social policy. One of Britain's leading public health officials described this potential breakthrough

> With wider and more exact knowledge of hygiene, it is being increasingly realized that the whole range of the physical, mental and to a large extent of the moral life of mankind may be brought within the range of preventive medicine...(Newsholme[1] 1909:403).

The rapid expansion of public health programmes in Britain and Canada in this period further indicated that a breakthrough was under way. In Britain, new programmes were introduced and old ones grew rapidly in such areas as: infant mortality (health visiting, mother and child clinics), child health (school medical inspection, treatment and meals), tuberculosis (sanatoria, health visiting) and sexually transmitted diseases (clinics, propaganda campaigns). Similar growth occurred in Canada, where public health officials found themselves heading new or expanded programmes in such areas as: infant mortality (public health nursing), child health (school medical inspection), tuberculosis (tuberculosis or public health nursing), sexually transmitted diseases (propaganda campaigns), mental handicap (programmes for the 'feebleminded') and immigration (medical inspection at the border).

The transformation of public health in this period is often explained internally, in terms of developments within the field. Rosen (1958:332), for example, emphasized the impact of advances in medical science on the development of what he described as the

'bacteriological era' of public health beginning about the turn of the century. This thesis will argue that the rapid development of public health in this period did not result solely from developments within public health. Rather, the expansion of public health was one of the features of a broad social policy shift which took place in this period. In Britain, Canada and other developed capitalist countries, social policy was receiving new attention at this time as part of a project of nation (and empire) building.

This new attention to social policy took place against a general background which included: the intensification of international political and economic competition culminating in World War 1, the increasing organisation and militancy of workers peaking in the post-war revolutionary wave and the acceleration of the international mobility of labour. These conditions were seen as creating a range of connected social problems, which were frequently conceived (in public health and social reform circles) in terms of the threat of 'race degeneration'.

The major tenets of the theory of race degeneration could be summarised in the following way. The working class was in physical, mental and moral decline due to the influence of poor living and working conditions. Family life was in disarray, due primarily to the deterioration of women's domestic labour under the pressures of paid employment for women, demoralisation in the face of poverty, and sheer ignorance in an increasingly complex world. Further, the increased mobility of labour nationally and

internationally generated questions about settlement patterns, cultural compatibility and racial stock.

Race degeneration was seen as threatening on the basis that it enfeebled the working class, the basis of national defence and prosperity. P.H. Bryce (1919:326)[2], one of Canada's most prominent public health officials, wrote that the impulse towards public health measures derived primarily from the need to improve the supply of "man-power" for work and war.

> Today, there can be no doubt but that the direct effect upon what we call the man-power of the country is the motive influencing action with a view to saving the lives of the citizens who are the source of power whether for national defence or economic progress.

The response to this perceived threat of race degeneration centred on a new effort to build the nation through the state in the interests of all. This nation-building project had two major dimensions. First, national working classes were increasingly delimited through immigration controls and similar mobility restrictions. Secondly, the self-reproduction (the maintenance of the living and their generational replacement) of this delimited population was subjected to increasing regulation, particularly through the supervision of the domestic labour of women but also through the control of certain working and living conditions. Below, this twofold process is described as the 'nationalisation[3]' of the working class.

There were substantial similarities between the way this process was played out in Canada and in Britain, as well as important differences. In both of these countries, the spread of

social work as a method of regulating the family was central to the developments of the period. In Britain, this period also saw the preliminary development of social welfare (i.e. benefits paying) programmes such as Pensions (1908) and National (health and unemployment) Insurance (1911), as well as the increasing specialization of social and health services. In Canada, developments in the area of social welfare were minimal, and health and social services remained largely undifferentiated. Further, immigration lay at the centre of social policy concerns in Canada while being far more marginal in Britain.

In both Britain and Canada, public health was on the forefront of this shift in social policy. Public health programmes were among the most important in the application of social work methods to the regulation of the family, particularly through the supervision of women's domestic labour. A range of new services developed under the aegis of public health were at the centre of work to reinforce and supplement the family in child rearing. Public health officials played a leading role in the introduction of immigration controls in Canada and to a lesser extent in Britain.

This, then, was the basis for what seemed to be a breakthrough in public health theory and practice during this period. In the event, this breakthrough turned out to be short-lived and limited relative to officials' aspirations. Rather than the basis for a permanent breakthrough for public health, this period proved to be a transitional moment in the development

of state medicine and social policy. Public health played a crucial role in defining new problems as objects of social policy. However, it could not provide the appropriate solutions, which were to come eventually from social work and welfare in combination with state-funded health care focussed on medical treatment.

It is the character of this transitional moment that makes it a rich ground for research, as it saw reflexive state officials expanding the frontiers of state activity, constructing and attempting to solve new problems in social reproduction. Public health approached the social reproduction of the working class in a relatively holistic way, attempting a systematic overview of a range of connected problems. Since then, the development of social policy has tended to fragment services and compartmentalize problems. The examination of public health in this period provides a good vantage point for examining the self-defined goals of state officials in the regulation of social reproduction.

1.2 The Critique of Public Health

The officials directing public health in the period 1900-20 were often theoretically sophisticated and reflexive. This was not simply a matter of individual qualities, but of the nature of their work in a transitional period. These officials were advancing the frontiers of state activity, experimenting with new modes of intervention, working out a new understanding of the

relationship between the public and the private in social reproduction.

This study examines in detail the social theory developed and employed by public health officials in this period. It follows the example of Abrams (1968) Corrigan (1977) and Corrigan and Sayer (1985) in taking the science of social policy formation seriously as sociology. It examines both the methods behind their thinking and the content of their analysis.

The critique of bourgeois thought has a long legacy within Marxist social science. The critique of political economy was the single greatest focus of Marx's work[4]. I do not claim in this thesis to be reproducing the sweep or power of Marx's critique of political economy. The central element I do take from Marx is the emphasis on identifying the way in which historically specific characteristics of capitalism are incorporated into bourgeois theory as natural laws. Most important in Marx's work was the specification of the value form under capitalism, in contrast with the greatest representatives of bourgeois political economy.

> The value-form of the product of labour is the most abstract, but also the most universal form of the bourgeois mode of production; by that fact it stamps the bourgeois mode of production as a particular kind of social production of a historical and transitory character. If then we make the mistake of treating it as the eternal natural form of social production, we necessarily overlook the specificity of the value-form, and consequently of the commodity-form together with its further developments, the money form, the capital form, etc (Marx 1977:174n).

The best of bourgeois science can maintain its objectivity while at the same time masking contradictions on the basis of the

identification of the conditions for the perpetuation of capitalism with the requirements for the reproduction of society. This need not be an intentional ideological exercise (though it may well be), but is the result of ahistorical thinking which interprets transitory conditions as eternal and sees the past and future only as more or less of the present.

Public health theory is an excellent example of bourgeois social science which represented the specific requisites for the perpetuation of capitalism as the general conditions for the maintenance of society. Officials saw the goals of public health as neutral, objective and scientific. They did not see themselves as taking sides in the conflict between classes. They criticised capital as well as labour, calling for social reforms to attack the perceived greed of capitalists as well as the perceived ignorance of workers[5]. They sought to improve social efficiency in the best interests of all, to perpetuate the nation. If anything, they saw themselves as pragmatic advocates for the disadvantaged.

Yet at another level, this conception was far from neutral. The society being reproduced had a definite shape, given social relations, particular dynamics. These fundamental characteristics were incorporated into public health theory as the bounds of the possible[6]. The improvement of society within those bounds could only be achieved by making capitalism work better: reducing surplus exploitation, enhancing labour productivity and military effectiveness, strengthening the

family, bolstering the nation. Public health officials constituted the historically specific conditions of capitalism as natural, eternal and immutable requirements for the perpetuation of society[7].

Of course, it was not simply a mistake at the level of ideas that lead public health officials to constitute these conditions in this way. Within capitalism, the limits of capital really do act as bounds of the possible for state activity. The state can only exceed the limits of capitalist reproduction at the cost of provoking social breakdown marked by a crisis of material production, international relations and class struggle (Clarke 1983:123). Thus these limits were incorporated into public health theory as a reflection of the lived reality of capitalism and not merely as an ideological error. Marx (1977:168) argued that this was a common feature of bourgeois social science.

> Reflection on the forms of human life, hence also scientific analysis of those forms, takes a course directly opposite to their real development. Reflection begins post festum, and therefore with the results of the process of development ready to hand. The forms...already possess the fixed quality of natural forms of social life before man seeks to give an account, not of their historical character, for in his view they are immutable, but of their content and meaning.

Central to the critique of bourgeois social science is identification of those apparently neutral concepts embedded in the conceptual foundation which serve to orient the whole theoretical edifice towards taking as given capitalist social conditions. In early twentieth century public health the most important of these were nation and family. Public health

officials saw the well-being of the nation (identified with the state; defined against particular interests at home and competing interest abroad) as the basis for the health of all. The well-being of the nation depended largely on the effectiveness of the family system in mobilising the domestic labour of women to turn out a population that was adequately fed, clothed, disciplined, etc.

This thesis looks in detail at the orientation of public health theory and practice around the nation and the family system. I will argue that these historically specific forms were taken as universal requisites for the reproduction of society. This meant that in the name of improving the health of the community in the interest of all, public health contributed to the production of a divided and stratified working class whose well-being was defined by functional ability in work, war or domestic labour.

This critique of public health theory as social science has a three-fold purpose. First, it allows us to cull out the strengths as well as the weaknesses of public health theory. Public health officials had a very sophisticated understanding of social reproduction from the perspective of the capitalist state. Their theoretical legacy has a great deal to contribute to our own understanding of the state regulation of social reproduction. The legacy is particularly instructive on the relationship between the labour supply, the sexual division of labour and divisions on the basis of race and nationality as seen from the

point of view of state officials.

Secondly, in unpacking the apparent neutrality of this theory we can better understand the process through which the limits of capital act as bounds of possibility in social policy. A central sticking point in Marxist theories of the welfare state has been the explanation of the relationship between social policy, the class struggle and the reproduction of capital. One way to advance in this area is to examine the way this relationship works in specific instances.

Thirdly, public health has been one of the most important alternatives to contemporary clinical medicine. It has served as a model to advocates of radical or socialist health care, ranging from the architect of the British National Health Service (NHS) to the 'new environmentalists' who have resurrected public health since the 1960's[8]. The examination of public health at its pinnacle is one way of understanding its strengths and limitations today as either a functioning programme (as in the area of AIDS) or a potential alternative.

1.3 Locating This Thesis: Marxist Theory, Social Policy and Public Health

A. The Definition of the Project

The central project of this thesis from the outset has been to contribute to Marxist theories of the state and social policy. This interest developed initially out of work experience in the social services, particularly in a housing service for people coming out of psychiatric hospital. It was pursued in my Master's thesis on the origins of psychiatric deinstitutionalization in Ontario, which argued that this shift in theory and practice originated not as a cover for cuts, but rather as a more effective means of returning workers to wage or domestic labour.

As I began to work out the direction for my Ph.D. thesis, I decided to broaden the scope of study both substantively and theoretically. Substantively, I wanted to move from the examination of mental health treatment specifically to the wider field of state funded health care. I initially conceived this project as an inclusive history of state-funded physical and mental health services in Canada and Britain from the origins of capitalism to the present day. Theoretically, I had hoped that this inclusive history would provide an appropriate empirical ground on which to develop a holistic Marxist theory of state social policy activity.

The thesis which ultimately emerged is considerably more modest than that initial project, due in large part to the advice of my supervisor, Simon Clarke. He offered two crucial

suggestions regarding the shape of the thesis. First, he stressed that theoretical problems cannot be overcome simply at the level of general theory, and that specific substantive work could contribute a great deal to Marxist work on the state and social policy. Secondly, he suggested that I address theoretical problems as they emerge out of the analysis of the empirical material, rather than attempting from the outset to produce a synthetic theory of the state based on reading everything ever published on the topic.

This is not to say that the approach was to be completely inductive. On the contrary, a basic theoretical orientation including a critical reading of secondary material was a crucial starting point for the thesis process. Beyond that, however, I began to work at a much lower level of abstraction attempting to develop theoretical explanations for specific problems emerging from the research.

The end result, then, is a theoretically-informed historical examination of a particular area of social policy. This produces questions and explanations which can be read back into the broader literature on the state and social policy. However, the thesis in itself lays no claim to offering a complete Marxist theory of state regulation.

This section is a return to the starting point of the thesis, the basic theoretical orientation grounded in the broad literature covering the state and social policy. It is not intended as a comprehensive review of everything written in the

area, but rather as an attempt to make explicit the implicit theoretical orientation of the thesis. The form, therefore, is autobiographical (discussing sources which influenced me and the direction of my thesis).

B. Theories of the Welfare State

At a theoretical level, this thesis represents an attempt to build on the insights of existing Marxist welfare state theories, while addressing certain key problem areas remaining in the analysis. The major focus of Marxist work on the welfare state has been the analysis of one central contradiction: the welfare state is at once a product of working class struggle and a means of providing requirements for the reproduction of capital. On the one hand, it has to be attacked as an agency of social control, which offers services and programmes only under conditions which perpetuate poverty, dependence on the wage and the sexual division of labour. On the other hand, it has to be defended against attacks aimed at cutting working class living standards.

The great contribution of works such as Corrigan and Leonard (1978), Ginsburg (1979), Gough (1979), Jones and Novack (1980) and Saville (1957) is that they illuminate this fundamental contradiction. I am not claiming that these varied sources represent a single body of work, but rather that they tend to result from a common set of premises and methods. These works show that the welfare state would not have developed without

working class struggle, even if the programmes and policies which emerged were neither shaped nor controlled by workers or their organisations (See Ginsburg 1979:7-10, 46-7). They demonstrate the contribution of social programmes to the perpetuation of the capitalist system through regulating the reproduction of labour power and the non-working population in order to provide the quality and quantity of workers required in the process of production (see Gough 1979:45-8,62). They show how the state assumes policy responsibility for regulating this reproduction which cannot be accomplished at the level of the individual competitive firm (Jones and Novack 1980:147-50).

This work represented a tremendous contribution. It provided a clear alternative to the dominant orthodoxy, shared by conservatives and social democrats alike, that the welfare state was in some way socialist or at very least non-capitalist. At the same time, it provided a theoretical framework for explaining how social policies of indisputably capitalist character could issue from working class struggles, both economic and political.

The conclusions of the body of work were in many ways the starting points of my research. I could begin with a whole foundation of premises regarding the character of the welfare state that had been worked out elsewhere. At the same time, the specific theoretical orientation of this thesis emerged out of perceived shortcomings in this body of work.

The major weakness that I felt remained in this body of work was a tendency to resolve a contradictory process one-sidedly (or

at times dualistically). The welfare state emerges from struggle, embodies the capital-labour contradiction, and yet at the end of the day serves "the long-term interests of the ruling class" (Corrigan and Leonard 1978:94-5). This tends to leave this work open to criticism on the grounds of functionalism, ultimately explaining a social practice in terms of its social role rather than contradictions (see Giddens 1979:131).

I believed that this could be traced back to two crucial conceptual problems which tended to recur in this work. The first of these is the narrow conception of the working class both as the subject (the driving force behind) and object of social policy. The second is a failure to provide an adequate account of the process linking social policy and the limits of capital, resulting in a tendency towards functionalist explanations. I will first flesh out these problems as found in the body of work on the welfare state identified above. I will then lay out the sources that influenced my critical reading and the direction towards resolving these problems emerging out of those sources.

Marxist work on the welfare state has tended to conceive the working class rather narrowly both as subject and object of social policy. As the subject of social policy, the working class has tended to be reduced to an input to state policy. This has occurred in two ways. The first has been to understand the class struggle around social policy in terms of specific welfare demands articulated and fought for through the official organizations of the labour movement, particularly parliamentary

social democracy and trade union centrals (see Ginsburg 1979:8-9). This conception comes very close to making the working class an 'interest group' in a marxianised version of pluralist state theories.

The second is based on a broader conception of the working class which incorporates a sense of struggle in the workplace. This conception tends to see periods of intensifying militancy as a source of pressure on the state which is temporarily reduced through the introduction of social programmes. Jones and Novack (1980:158) explained working class unrest as "...one of the key triggering factors in the timing of social policy development." Gough (1979:65) argued that workers' militancy "...galvinises the ruling class to think more cohesively and strategically, and to restructure the state apparatus to that end."

The problem with both of these views is that they can easily end up trapped in a view of the state as some sort of mediating force forging policy out of competing inputs from workers and capitalists. This can have the impact of distancing social policy from actual struggles at the point of production, touching on these only as they become problematic for the state at peak periods of struggle. Further, it can create a sense of the state as a quasi-autonomous mediating agent which is difficult to reconcile with the structural limits on state activity.

This limited conception is very much mirrored in the portrayal of the working class as object of social policy. This begins with the theoretical separation of the reproduction of

labour-power from that of the non-working population (Gough 1979:44-8). Yet labour-power cannot be reproduced as such, but only as a working class which includes potential wage-labourers. The reproduction of the working class necessarily involves the maintenance of members who are temporarily or permanently not employed or regarded as unemployable.

The separation of the reproduction of labour-power from that of the non-working members of the working class is problematic in a number of ways. First, it tends to obscure the necessary relationship between wage-labour and domestic labour in reproducing the working class, so that the 'non-working' or underemployed are often the most directly engaged in private, unpaid reproductive labour. Secondly, it tends to lead to a division of social programmes into those based on an economic rationale (reproducing labour-power) and those based on a political one (procuring social harmony through maintaining the non-working). This approach tends to reproduce the fragmentation into a variety of supposedly distinct jurisdictions (e.g. labour relations vs. welfare programmes, immigration controls vs. education) of the range of social programmes which regulate the reproduction of the working class.

The second problem in this literature is the tendency to provide a weak account of the process linking social policy to the reproduction of capital. Clearly, significant sectors of the capitalist class often oppose the social policy reforms introduced in their 'long term interests'. State policy makers

repeatedly assert their neutrality in the conflict between labour and capital, stressing that they represent the interests of the nation as a whole. The process through which policies introduced in response to working class struggles become programmes serving the interests of capital (over the opposition of capitalists) needs to be explained. There has certainly been some attempt to bridge this gap in the literature (Saville 1957:10-11, Gough 1979:62), but further work is required to clarify how state policy-makers can see themselves as neutral, and yet enact reforms in the long term interests of the ruling class, reforms often bitterly opposed by those who apparently benefit from them.

I am not identifying these two interrelated problems here as the basis for claiming that I successfully overcome them in the thesis. Rather, these should be regarded as an orienting problematic, a direction requiring further work to which this thesis might be a contribution. The first step in this process was to muster other sources which might lead in theoretical direction of solving these problems.

C. Marxist Theories of the State and Wage-Labour

The problems of conception of the working class and of the relationship between social policy and the reproduction of capital did not result from inconsistencies or poor formulations. Rather they resulted from the nature of the questions posed. To get to the question of how the welfare state yields from working class struggle and yet contributes to the reproduction of capital

it is necessary to start with a broader conception of the reproduction of wage-labour and the state regulation thereof.

I therefore felt it was necessary to pass through theories of wage-labour and state regulation on the way back to theories of social policy. This, together with new empirical work, would provide the basis for a theoretical contribution to Marxist work in this area.

The basic theory of the wage-labour was drawn from Lebowitz (1982:43-8). In that article, he shows the contradictory unity between the reproduction of capital, in which workers are used up in the process of production in exchange for a wage, and the reproduction of wage-labour in which workers are replenished (both daily and generationally) through the exchange of the wage for means of subsistence consumed through a private labour process relying primarily on the unpaid labour of women in the home. Thus, labour and capital are at once mutually dependent and perpetually in conflict, as the needs of capital for workers and those of workers for themselves (sufficient means of subsistence, 'leisure time' for reproduction, etc.) are necessarily contradictory.

The basic approach to the state came from Clarke (1983). This article portrayed the state as a historical product of class struggle which emerges as a means of overcoming the barrier to the reproduction of capital posed by the working class. This is an unequivocally capitalist state, which can exceed the limits of

capital only at the cost of provoking economic and political crisis.

These two sources were combined with four others which addressed the specific question of state regulation from somewhat different angles. Aumeeruddy et al (1978:48-9) discuss the need for state regulation processes outside of the realm of commodity production to realise the potential wage-labour borne by workers who are socially reproduced. Aglietta (1979:71-2) located these regulation processes within a broad pattern of regimes of accumulation which combine welfare policies, labour relations, social consumption norms, etc.

Corrigan and Sayer (1985:4-5) showed that these processes rely heavily on moral as well as economic regulation. As well, this book and Corrigan's thesis provide excellent examples of taking the policy-formation process seriously. Topalov (1985:259) discussed not only the problem of functionalism in Marxist theories of social policy, but also identified the process of "transformation, reformulation and displacement" between workers struggles and social policy responses.

My engagement with this literature in response to the problems identified above led to the following theoretical direction for the thesis. I could not deal in any depth with the question of the working class as the subject of social policy. This would require a detailed analysis attempting to connect advances and declines in shopfloor struggles to the political response of the state, with a general hypothesis that welfare

state programmes tend to generalise some of the gains of the most advanced sectors of the working class in periods of rising militancy and to be a prime target of employers in times of declining militancy.

I worked with a broad conception of the working class as the object of policy. This included a commitment to examine the relationship between wage and domestic labour, and the combination of economic and moral forms of regulation. In the area of social policy and the reproduction of capital, I attempted to take seriously the stated intentions of policy-makers and to relate those back to Marxist claims regarding the non-neutrality of social policy.

This was roughly what I knew when I began intensively reading secondary and then primary material on public health. Fairly quickly it became evident that these theoretical strands could be drawn together for this particular thesis through concentrating on the importance of nation and family as key orienting principles in the development of public health. This had the advantage of forcing the conception of working class formation outward, to include the crucial processes of creating national working classes and regulating the family system. At the same time, the examination of these orienting principles provided the key for understanding the apparent neutrality of public health based on claims of representing the health of the nation and the family.

This direction, however, presented me with a new problem. The issues of nation and family opened me up to two new areas of study, each with an immense literature. The literature on nation building included works on imperialism and immigration policies. The literature on the family system included the contentious debates of the past twenty years on the character of domestic labour and the basis of women's oppression. There was no way that I could be comprehensive in reviewing the literature in each of these areas.

D. The Nation, Immigration and the Age of Imperialism

The period 1900-20 was initially selected as the focus for the thesis on the basis of its importance within public health, representing a crucial turning point between the old sanitation and the new hygiene. As the research developed, it became clear that this turning point in public health was one aspect of a broader shift in state policies connected to a broader project of nation-building. This project was most advanced in Britain in the Age of Imperialism, though it was also significant in Canada and other developed capitalist countries.

There is a strong secondary literature on British social policy in the age of Imperialism. For this thesis, I used Semmel (1960) and Davin (1978) who most directly related the imperialist project to the goal of social improvement at home. I linked these interpretations to Thane (1982) and Stedman Jones (1971) who connected the changes in British social policy in this period

primarily to internal class relations. These accounts were complementary, and furnished a good basic understanding of British social policy in the Age of Imperialism. None of these, however, theoretically connected these events to a broad project of nation-building sweeping the developed capitalist world which included both early steps in the delimitation of national working classes through various means of mobility control and their improvement primarily through the regulation of the family system though also through economic social programmes.

In Canada, there are no parallel accounts of the development of social policy in the age of imperialism. There are some fairly good books on the social history of the period, though they tend to operate at a fairly low level of abstraction. Cook wrote a very good intellectual history of urban reformers, which does not really examine the social context for the ideas. Urban historians like Artibise and Stetler (1981) Armstrong (1968), Copp (1974) and Piva (1979) related the impulse to social reform in this period to the complex of problems issuing from immigration, industrialisation and urbanization. While Copp and Piva explicitly raise the question of class relations in this context, it is primarily connected to an expository project of demonstrating that reformers were not simply altruistic humanitarians.

Interestingly, there is no single, authoritative account of Canadian immigration policies in this period. Avery (1979) who concentrated on the development of immigration controls based on

political criteria in response to the growing radicalism of the Canadian working class peaking in 1919. Troper (1972) examined the focus on promoting peasant immigration into Canada, relating that to the development of exclusionary measures against black immigrants. Bilson (1984) and Roberts (1988a) examine the development of the medical inspection of immigrants in Canada, both concentrating on the mix of medical and social criteria in the exclusion of immigrants. Dyzek (1982) wrote about the deportation of immigrants, stressing that it was an economic response to unemployment, while Roberts (1988b) argued in response that it was also a political response to radicalism.

None of these sources contains a systematic theoretical argument for the development of immigration controls in this period, and none related immigration controls to the priorities of domestic social policy. Castles and Kosack (1985) and Miles (1986) covered British immigration in this period, and similarly did not raise the two questions just mentioned.

E. The Family and Domestic Labour

The question of the family and domestic labour presented me with a thorny question. Here I was confronted with an immense (Hamilton 1987:460 n.5 cites Kaluzynska's figure of over fifty articles in the previous decade) and highly contentious literature. It would be impossible to complete the thesis within three years, doing a thorough job of the primary research, at the

same time as weighing in to the debates on theories of domestic labour and women's oppression.

I thus employed the following strategy. I used Leibowitz and Vogel as the guides to a basic Marxist analysis of domestic labour in the process of social reproduction. I stated explicitly that this paper could say something about the state regulation of the domestic labour process, but it could not cast any light on the question of how this labour came to be primarily the responsibility of women (Fox 1987:184). This state regulation was crucially connected to the character of domestic labour as atomised in separate households, not subject to direct supervision, seamless and endless.

The thesis largely took for granted the large amount of excellent work on the character of housework produced by feminists, socialist feminists and marxists in the past two decades. The thesis stands on the previous work done by Oakley (1974:4) on the contradictory character of housework as work and not work; by Barrett and McIntosh (1982:60-4) on its "oppressive inevitability" for women and the insidious nature of standards for work in the home; and by Luxton (1981:18) on its continuous and seamless nature.

The character of housework, however, is not the issue of contention. The major theoretical issue at stake is whether the burden of domestic labour that falls mainly upon the shoulders of women (whether or not they are employed outside the home) should be explained in terms of the dynamics of patriarchy, capitalism

or capitalist patriarchy. This indeed was the major issue at stake through the whole domestic labour debate, even as it spun off into a range of what Seccombe (1987:191) called "taxonomic" questions regarding value and productivity in the Marxist sense. It is beyond the bounds of this thesis to address that issue, as interesting and important as I believe it is.

F. Public Health Histories

Thus far this review has concentrated primarily on the theoretical literature used to orient this thesis. It was also necessary to find an orientation to the literature on the substantive focus, the history of public health. In very general terms, this literature tended to explain the development of public health in terms of the progress of science. Even Rosen's seminal history of public health, which does ask a variety of socio-political questions about public health, tends to see the development of the new hygiene primarily in terms of medico-scientific progress. This thesis, in contrast, has explained the transformation of public health primarily in terms of changes in state social policies

Public health histories in Canada have tended to take the form of studies of one locality or policy area. The most useful source for this thesis has been the work of Bator (1979a&b, 1980, 1983) on the development of public health in the City of Toronto. Bator touches on a number of the sociological questions investigated here (immigration, women and the home, public health

and social policy), yet without attempting to develop an overall theoretical analysis. Andrews (1979) studied the early years of public health in Vancouver in a parallel manner, though with less attention to some of the social-political issues explored by Bator and more interest in issues of professionalisation, the role of experts and the institutionalisation of state medicine.

Sutherland (1976) and Lewis (1982) both looked at public health policies oriented to children, both raising pointing to interesting contradictions in this area yet without placing this within the context of broader questions concerning the family and the development of social policy. Piva (1979) and Copp (1974) both examine public health in their social histories of local working classes, emphasizing the narrow class interests (as opposed to universal humanitarian interests) of reformers though without raising any questions about the character of the capitalist state. McGinnis (1980) studied the rise of public health in federal government policy and its ultimate supercession by curative medicine. Again, exhaustive and stimulating work that does not attempt to deal with the important theoretical questions it raises (or could be seen as raising). Finally, Defries (1940) and Le Riche (1979) provide institutional histories from within public health practice which tend to be arid and bereft of sociological content, providing an unproblematic account of medic-scientific progress.

There is more literature in Britain which studies public health as a unitary phenomenon, most likely due to the historical

prominence of the national state in generalizing and promoting new programmes. Frazer (1950) provided the most comprehensive overview, operating within the progressivist framework. Finer (1952), Eyler (1979) and Lambert (1963) studied the major figures in nineteenth century public health, producing sociologically-informed biographies of Chadwick, Farr and Simon. Wohl (1983) did a broad study of nineteenth century public health programmes from a critical but low-range theoretical perspective. Hodgkinson (1967) studied state medicine in the nineteenth century, which documented the relationship between public health and curative treatment. Finally, Corrigan (1977) and Davin (1978) provided the closest models to my own thesis, using empirical work (the former on Chadwick, the latter on early twentieth century new hygiene) as the basis for higher-range theoretical argument.

G. Comparative Literature

It is clearly recognized in the Marxist literature on social policy that comparative-historical studies must play an important part in theoretical development in this area (see Gough 1979:56-7). My interest in this kind of work developed out of reading British works on the state and social policy from a Canadian perspective. In British history, there is a very obvious connection between the election of the Labour Party and the implementation of the post-World War Two welfare state. In Canada, social democracy was far less important in the

development and implementation of welfare state reforms. This is not to deny the importance of pioneering legislation in Saskatchewan, the only province to elect a social democratic government before 1969. Nevertheless, the welfare reforms were introduced in most provinces and at the federal level by Liberals and Tories.

I started off, then, with a rather obvious example of the reality that one must be very cautious in generalizing from a particular case to the general tendencies of capitalism. This was a push in the direction of comparative historical work. Ultimately, however, the claims that can be staked for the comparative aspects of this thesis turned out to be very modest.

This thesis ends up being what Skocpol and Somers (1980:176-8) call a "parallel demonstration of theory." The aim is to

> persuade the reader that a given, explicitly delineated hypothesis or theory can repeatedly demonstrate its fruitfulness- its ability to order the evidence - when applied to a series of relevant historical trajectories.

The aim then is to show that the explanation has power in two or more cases, but not to do the controlled comparison of similarities and differences that would allow one to begin to cull national contingencies from broader transnational patterns. This second kind of comparative work is what Skocpol and Somers (ibid:181-7) call 'macro-causal analysis'.

This thesis basically abstracted the phenomenon of 'public health in general' and then examined how this worked itself out in two specific cases. This contributed to the thesis through broadening the scope of the explanation, so that it had to

encompass for example not only the established slums of England but also the influx of immigrants to a new world settler state. I believe it would have been far more difficult to understand the whole process of nation and family formation in public health through reference to only one or the other of these cases.

This thesis does not, then, fill the much identified gap in comparative historical studies of the welfare state through providing a methodologically powerful comparative analysis. It is an historical work with a comparative dimension. I would argue that such a comparative dimension can be extremely valuable, even if it does not attain the rigorous standards required for controlled causal analysis.

1.4 Theory, Evidence and Generalisation

This thesis is not a conventional exercise in theory testing. Hypotheses are not operationalised and subjected to a definite process of testing leading to some kind of confirmation or rejection. The relationship between theory and evidence here is rather different, and therefore requires some explanation.

This thesis is a theoretically-informed examination of public health theory as found in specific documentary materials. It begins with a set of theoretical premises perhaps best summarised in a quote from Marx (1959:791-2).

> The specific form in which unpaid surplus-labour is pumped out of direct producers, determines the relationship of rulers and ruled, as it grows out of production itself and, in turn, reacts upon it as a determining element...It is always the direct relationship of the owners of the conditions of production to the direct producers - a relation always naturally corresponding to a definite stage in the development of the methods of labour and thereby its social productivity - which reveals the innermost secret, the hidden basis of the entire social structure, and with it the political form of the relation between sovereignty and dependence, in short, the corresponding form of the state.

The form of the state, then, derives from the fundamental relationship of class exploitation in society as structured in a definite mode of production. The capitalist state, despite its appearance of autonomy deriving from historically specific conditions, is in no way neutral in this defining relationship of exploitation.

These premises, the centrality of class exploitation, the non-neutrality of the state, are in no way tested through this thesis. Rather, they are applied to the explanation of

particular events and patterns. Theory, then, is neither confirmed nor rejected but rather enriched through this form of engagement with empirical reality.

It might seem rather redundant to bother with empirical research if fundamental theoretical questions are regarded as answered in advance. But the elaboration of general theoretical premises regarding the central dynamics of the capitalist mode of production in no way replaces serious empirical work. The above quote from Marx (ibid.) continues:

> This does not prevent the same economic basis - the same from the standpoint of its main conditions - due to innumerable different empirical circumstances, natural environment, racial relations, external historical influences, etc., from showing infinite variations and gradations in appearance, which can be ascertained only by analysis of the empirically given circumstances.

Theoretical abstractions are necessary but not sufficient to capture the real movement of history. It remains to demonstrate how these fundamental tendencies are played out in situations of real complexity, through the conduct of definite historical actors. Sayer (1983:158) discussed the need for theoretical concepts at a high level of abstraction, but pointed out the concomitant need to grasp history concretely.

> But such concepts nevertheless remain abstract inasmuch as the relations and structures to which they refer do not exist outwith the actions of definite individuals as they eventuate over time, and these concepts are not yet concrete descriptions of these actions. To apprehend an essential relation <u>concretely</u> therefore entails grasping it as such a pattern of structured action over time, or in other words as <u>historical process</u>.

The task of this thesis is to apply theoretical concepts derived at a high level of abstraction to the understanding of

public health 1900-1920. The measure of success will be the degree to which the actual unfolding of events is effectively captured theoretically. Marx (1977:102) claimed success in such an enterprise, "...if the life of the subject matter is now reflected back in the ideas..."

In short, this thesis will have explanatory power if it successfully moves from abstract premises to the concrete analysis of real events, permitting some generalisation back to enrich the theoretical understanding[9]. Only if the concrete analysis really captures the complexity, contradictions and intentions of public health theory and practice will it pose those questions which demand a theoretical response.

The importance of the concrete analysis to the success of this study raises the question of the quality of the evidence amassed here. It is the nature of the kind of research done here that there are no specific criteria by which to assess the quality and adequacy of the empirical evidence as there are, for example, in statistical work.

This kind of documentary work necessarily involves a process of removing elements from their context and reconstructing them. The only alternative would be to reprint whole documents and force the reader to relive the research process. While there may be an art to this sort of sampling, there is certainly no science.

At the most rudimentary level, I have tried as much as possible to use full and extensive quotation with minimal editing

to represent the thoughts of these officials. More importantly, I have selected quotes which I believe generally represent (or where appropriate, conflict with) the logic of public health in this period. Probably the single most surprising discovery for me in this whole process was the sophistication, consistency and coherence of public health theory as sociology. The exceptions, those who cut against the basic methodology, ideology and sociology of public health, tended to stand out immediately. Public health in this period was a system and I have endeavoured to select samples that were either representative of this system, or in specified cases clearly not.

Through this process I relied heavily on the works of certain key officials. These key officials tended to hold prominent positions, to be recognised for their achievements by their peers, and to demonstrate an ability to use state policy science creatively. I have included brief biographies of these officials below in Appendix 1. I believe that their works not only represented, but contributed largely to shaping, the theory and practice of public health in this period.

Finally, this thesis involved extensive research within definite limits. I read through three public health journals systematically, one Canadian (Public Health Journal) and two British (Journal of the Royal Sanitary Institute and Journal of the Royal Institute of Public Health/ Journal of State Medicine/ Journal of Preventive Medicine). I did some reading of other public health and medical journals. I systematically read the

Annual Reports of specific government departments in Canada and Britain, as well as Royal Commissions and similar investigations with a public health mandate (see bibliography). I read some public health books from the period, and some publications aimed at the general public.

I would argue that this extensive research within definite limits in combination with the emphasis on key policy-makers has provided me with a firm basis on which to make judgments. I would claim that the system I identify as operating through public health policy science is not simply a retrospective construct imposed on events but was actually there in contemporary writings.

Despite all this, I am quite sure that someone else could do the same research and come out with quite a different analysis equally grounded in the evidence. In such a case, though, I do not believe that it would be the sampling technique or reliability of the key officials that would be at issue, but rather the explanatory power of the theories used and the effectiveness of the general methodology.

1.6 The Comparative Method

This thesis centres on a comparison of public health theory and practice in Britain and Canada. The aim of the comparison was to provide some basis for sorting out similarities which could be linked to the general character of the capitalist mode of production and the limits of the state, from differences which

would be explained in terms of contingent social and historical aspects of each country's development. It is the nature of such a comparison that it cannot be definitive as there are too many complicating factors such as the diffusion of ideas from one country to another which might provide bases for alternative explanations.

The general differences in political and economic conditions between Britain and Canada in this period were sufficiently marked to provide for an interesting comparison. Britain was the world's first industrial power. By the turn of the century, it had a long history of industrial development, proletarianisation of the producing population, urban development, class struggle and regulation through social policy. It was at the centre of a global empire which was under increasing threat from serious competition.

Canada was in a process of rapid industrialisation in this period. It was accumulating workers and farmers through massive immigration. Social problems were regarded as new developments around the turn of the century. Social services tended to be newer, less extensive and less differentiated than those in Britain. As a section of the British Empire which was increasingly achieving a level of political autonomy, questions of nation and empire tended to focus more immediately on national formation than on imperialist competition.

There were important differences in the public health apparatus and the problems it confronted in these two countries

as this period began. The older British public health system faced established conditions of urban poverty defined as pressing problems in the context of imperial crisis and intensifying class struggle. The newer Canadian public health system was developing as a response to the apparently novel and related issues of rapid industrialization, the growth of slums and heavy immigration.

Despite these broad differences, there were remarkable similarities between British and Canadian public health in this period. In both countries, home visiting programmes aimed particularly at wives and mothers figured prominently in public health in this period. These programmes were aimed primarily at education, teaching domestic hygiene to home-makers in their own setting. This educational emphasis derived from the view that ignorance was the major cause of the most important diseases and disorders, including tuberculosis, infant mortality and sexually transmitted diseases.

These similarities can be traced to two roots. Despite important differences, much of the situation of the urban slum dweller was common to both countries. In both cases, one found high incidences of infant mortality, inadequate and overcrowded housing, malnutrition, the paid employment of mothers without provision for child care, high rates of tuberculosis, and so on. In this period, public health was oriented particularly to this stratum of the population.

The second reason for these similarities related more to the character of the capitalist mode of production and the limits of

the state. The general character of wage and domestic labour in the two countries was a product of capitalist relations. The material and ideological limits on the direct provision of money goods and services through the state derived from these basic relations. Public health in both countries was faced with negotiating these limits all the time.

These similarities, then, can be related in a general way to the character of capitalism as a mode of production. At the same time, there were important differences between the countries. Most important was the fact that British public health programmes tended to be more centralised on a national basis and extended farther in the direction of direct state provision (especially through school meals and medical treatment) than those in Canada. This difference can be explained largely in terms of the greater degree of working class organisation in Britain (that is, the degree to which the working class had made itself a problem for the state) and to the history of state activity, imposing political and economic constraints on the present particularly through the Poor Law which had a tremendous influence on the shape of public health programmes.

Thus, the comparative method used here provides some basis for sorting out the general tendencies of capitalism from specific contingent developments in the analysis of changing social policy. Yet there are many complicating factors in this sort of analysis, adding a tentative quality to the conclusions which may be drawn. In the case of public health, the whole

question of diffusion provides an excellent example of a complicating factor.

There is no doubt that public health ideas moved back and forth between Britain and Canada. This in itself could be used to explain the similarities between the two countries. There are two reasons that I would argue against an overly heavy emphasis on the diffusion of ideas. First, the mere existence of a model of public health theory and practice in Britain did not lead to similar developments in Canada for about half a century, until conditions defined as problematic led officials trying to respond to seek out models. Diffusion, then, only works when conditions are ripe and therefore the conditions as well as the spread of ideas must be investigated.

Secondly, there were important differences in similar programmes between Canada and Britain. Home visiting, for example, was done by health visitors in Britain and public health nurses in Canada. These differences suggest programmes of separate origins that converged to serve similar purposes rather than the emulation of models. This would tend to weaken diffusionist arguments.

There are tremendous difficulties with doing this kind of comparative research. A level of detail gets sacrificed and the number of complicating factors rises sharply. Yet I would argue that it can be very valuable in permitting us to identify the general features of the capitalist world system as they play

themselves in the form of social policy rather than emphasising exclusively the peculiarities of national development[10].

1.6 The Limits of the Thesis

The approach taken to the study of public health in this thesis imposes definite limitations on the work. This thesis began as an overly-ambitious plan to study all aspects of state health care in Canada and Britain from 1840-1980. It was narrowed down for practical reasons to the examination of one aspect of state health policy (public health) in one particularly rich transitional period (1900-20). The scope of the thesis was further limited on a methodological basis to a focus on one aspect of the development of public health, that of the policy-making process.

The thesis which has emerged centres on a critique of public health theory as articulated by key officials in Canada and Britain 1900-20. This critique is used to locate public health within the context of a Marxist theory of the state regulation of the social reproduction of the working class. In particular, the thesis revolves around the role of nation and family as key orienting principles in the development of public health as a method of state regulation.

This thesis, then, is not a complete history of public health in Canada and Britain 1900-20. The focus is on the theory of public health officials rather than their practice. The whole complex process of implementation, of local initiatives floating

up and directives forced down, of community acceptance or resistance, of negotiations both official and unofficial, is not really examined here.

This should not be taken as a claim that the study of state policy science is in itself completely adequate for all research on the state. Rather, this thesis should be seen as a close study of one aspect of the social policy process, showing how the limits of capital and the state define the bounds of the possible for public health at the level of theory. Research on the moment of implementation would undoubtedly add new factors, complicate the picture in useful ways, demonstrate the way that constraints were negotiated and read back into theory. Such research, however, lay beyond the parameters of this paper.

At a more general level, this thesis is a strictly delimited case study as part of a very broad theoretical project. There is a tension in the work between dealing exhaustively with concrete phenomena and working at higher levels of abstraction. In particular there is a risk of what Sayer (1983:121-2) following Marx called 'violent abstraction'.

> ...an idea of immediate identification of phenomena as supposed instantiations of general laws, when in fact these laws operate only in a mediate fashion through a series of intervening links which the analysis ought to specify.

This can be overcome only through exhaustiveness, "...developing the analysis to the point where no phenomenal residuum defying explanation on the proposed explanans remained" (ibid). In a project such as this, it is possible to strive for exhaustiveness within the narrow confines of the area of specific

study, attempting to fully explain the complexity and richness of real developments. Yet outside of those confines, in the analysis of important contextual material such as the character of social policy in Britain and Canada in this period, adequate exhaustive explanation has not been possible. It is simply beyond the limits of a work such as this to fully analyse the historical conjuncture.

This thesis inevitably touches on themes it cannot analyse fully. It can offer only a schematic sketch of the broad shift in social policy in Canada and Britain in this period, as it would be a whole other project to fully develop such a comparison[11]. It implies a particular relation between class, gender and race within public health policy and Marxist theory, and yet it cannot properly enter into the rich debates in these areas[12]. It suggests a particular relationship between immigration and social policy, and yet it cannot really examine the whole question of the mobility of labour under capitalism.

This thesis can be neither a definitive Marxist account of social policy in the early twentieth century nor a comprehensive history of public health in the period. Rather, it is a critique of public health policy science in this period which establishes an historical context as the basis for generalisation.

The thesis begins by situating early twentieth century public health at a particular moment in the development of health and social policy in Chapter Two. The importance of issues of nation and nationality in public health in this period is then

examined in Chapter Three, which focusses on a detailed case study of public health and the regulation of immigration in Canada. Chapter Four looks at public health and the regulation of the family through social work methods, concentrating on a detailed case study of these programmes in Britain. The thesis concludes with a discussion in Chapter 5 of what these case studies and comparisons suggest in terms of the generalisation towards a Marxist theory of the state regulation of the social reproduction of the working class.

Chapter Two
SITUATING PUBLIC HEALTH

2.1 The Health of the Nation

Public health is distinguished by two features. First, it approaches questions of health and illness at the level of society rather than the individual. Secondly, it is characterised by the use of state power to improve health; it is a specialised area within state social policy[1]. It can be described, in the words of W.H. Frazer (1950:1) as, "Action by the state to influence in a favourable sense the health of the community..."

The approach to health and illness at the level of society means defining ill-health as a social phenomenon and aiming to remove it through measures aimed at the community as a whole. Newsholme (1925:1) described the goal of public health:

> ...to conserve and promote the health of the community by forwarding measures calculated to enhance the general standard of health and by the removal of controllable influences provocative of disease.

Public health, then, advances through measures which could be characterised as "conducive to the health of the people as a whole" (Newman in UK.Health 1920:8). Public health locates illness as a product of social life, to be prevented or diminished through community measures.

> Throughout human history, the major problems of health that men have faced have been concerned with community life, for instance, the control of transmissible disease, the control and improvement of the physical environment (sanitation), the provision of water and food of good quality and in sufficient supply, the provision of medical care, and the relief of disability and destitution (Rosen 1958:25).

The central aim of public health is to prevent the spread of disease by removing those conditions which tend to promote it. The community measures involved have spanned the range from improving water supply and sewerage to educating mothers of infants to immunisation programmes on a national and world scale[2].

Of course, the health of the community does not exist independent of the health of individuals. Public health does not, however, approach the health of the community simply as the aggregate of individual health. An early British public health reformer wrote in 1870: "...hygiene deals with mankind not one by one, but in masses..." (Guy cited Lillienfeld 1982:145). It begins with a conception of collective health, to which individual interests must be subordinated. Bevan (1952:73) wrote of public health officials:

> ...the whole significance of their contribution is its insistence that the claims of the individual shall subordinate themselves to social codes that have the collective well-being for their aim, irrespective of the extent to which this frustrates individual greed.

This concept of collective well-being is at the heart of public health. The notion of collective well-being as employed here has specific political content. The agent for collective well-being to which the individual must be subordinated is the state. Newsholme (1925:72-3) offered a "more limited definition" of the goals of public health:

> ... to secure the best attainable health of each member of the community, so far as this is or can be secured by the action of local or central authorities concerned with any part of government...

The parameters of the community for the purposes of public health are political, the people belonging to a specific state. Public health refers to the health of nations.

> ...the national health is of supreme and vital importance as the foundation of the well-being of the individual, physical, mental and moral, and thus of the well-being of the nation (Newman in U.K.Health 1920:7).

This identification of the health of the individual with that of the nation is central to public health. It is a crucial orienting principle, bearing implicit content. The health of the nation depends on the availability of certain key resources (such as food, housing, medical supplies, etc.) and the marshalling of those resources to serve the needs of health. Given the limits of capitalism, the availability of such resources depends on the health of the economy, on the ability to achieve capitalist prosperity. The marshalling of resources depends on the regulation of capitalist reproduction so as to maximise the possibilities for health without contradicting the need for capitalist prosperity[3].

The health of the nation, then, is not a neutral term but one loaded with political content. The interests of the nation are seen as embodied in the capitalist state. In this sense the state is seen as representing the general interest of the whole population of a particular unit in the competitive world economy in achieving prosperity. This general interest exists in opposition both to particular interests within the nation, and to the competitive position of other nations in the world economy.

Public health, then, was one feature of state activity in the national interest which inevitably conflicted with particular interests, most importantly those of classes. Chadwick, for example, believed that workers and capitalists shared a common interest in better sanitation. He saw labour agitators, short-sighted employers and owners of small property as narrow-minded and even sinister obstacles to policy improvement in the interests of all[4]. Similar arguments can be traced from Simon in the 1860's to Bryce and Barr in the early twentieth century[5].

This national interest was also opposed to the competing interests of other nations. Such a view was present in a general form in Chadwick's seminal report.

> The greatest portion of the wealth of the nation is derived from the labour of the application of this strength, and it is only those who have practically the means of comparing it with that of the population of other countries who are aware how far the labouring population of this country is naturally distinguished above others (Chadwick 1965:252).

It became a more explicit focus of public health in the early twentieth century.

> ...we had now to think of the English people in competition with other races, and if we neglected the health of the race...we should lose in the racial competition of the world (Morant 1909:67).

From the outset, then, the framework of public health incorporated a concept of nation as a central orienting principle. The aim was national health, the health of the working class belonging to a particular capitalist state. In this sense, public health was more than a question of medical treatment and the suppression of contagion. It touched on a

range of questions concerning the regulation of conditions affecting the well-being of the working class. John Simon wrote, for example:

> The public health of a country means the health of its masses, and the masses will scarcely be healthy unless to their very base they be at least moderately prosperous (cited Newsholme 1925:163).

2.1.1 The Object of Public Health

The conception of national health discussed above would tend to indicate that health was measured by standards which extended far beyond the mere absence of disease. At its broadest, public health leaned heavily in the direction of moral as well as physical and mental measures of well-being. The basic definition of health employed in public health varied considerably, changing dramatically with the rise and fall of the new hygiene in the early twentieth century.

Health and illness are social constructions. Sedgwick (1982:30) wrote: "Outside the significances that we voluntarily attach to certain conditions, there are no illnesses or diseases in nature." The definition of health, then, is not given objectively but established socially in relation to specific norms. "All sickness is essentially deviancy." (ibid.)

The dominant conception of health in contemporary medicine has focussed on effective functioning. Doyal (1981:33) wrote, "...health is usually defined as 'fitness' to undertake whatever would be expected of someone in a particular social position." Normality, then, revolves around the ability to carry on with

work and/or domestic labour as well as other socially appropopriate activities.

Effective functioning is deeply embedded in the medical conception of health. It establishes the broad framework within more specific classifications of deviance and normality in health appear. Susser (1974:540) described three specific methods of defining normality with regard to health. The first is the pathological, in which "...normality (or health) is the absence of disorder, impairment or disease." The second is statistical, in which "...[i]ll health is defined by deviation from mode or mean." The third is by values, "Ideal norms point to how things ought to be..."

Public health began in the nineteenth century with a very specific conception of functioning effectiveness, financial independence as demonstrated by non-pauperisation. The seminal report for English-language public health, Chadwick's Report on the Sanitary Condition of the Labouring Population of Great Britain grew out of the work of the Poor Law Commission to reduce pauperism (dependency on Poor Law Relief). Chadwick attacked ill-health as a cause of pauperisation, the indicator of dysfunction[6].

Within this general framework stressing effective functioning, Chadwick and the old sanitarians defined health fundamentally in pathological terms as the absence of specific diseases. They were concerned particularly with a set of diseases linked to the condition of urban environments, such as

cholera, tuberculosis and typhus[7]. The aim was to improve the urban environment to eliminate the causes of these specific diseases so as to create a working class that was free to improve itself through the participation of at least some family members in wage-labour.

The new hygiene went beyond this focus on preventing specific diseases in order to reduce ill-health as a cause of pauperism. The conception of functioning effectiveness moved beyond the primarily negative focus of preventing economic dysfunction in the form of pauperism. The new hygiene sought to positively enhance the functioning of workers, soldiers and homemakers[8]. This recurrent emphasis on enhancing the ability to labour was reinforced by an effort to promote a range of skills and attitudes which could probably best be summed up as 'good citizenship' (McGregor 1904:420, Struthers 1913:67).

This positive conception of enhancing functioning effectiveness was connected to a conception of health that went beyond the pathological. The absence of identifiable disease was only one aspect of national health.

> ...it became increasingly evident that to deal, however adequately, only with children suffering from some obvious mental or physical defect was, after all, to leave some of the most urgent questions of school hygiene and national physique untouched (UK.Bd of Ed 1908:6).

Officials at the time commonly referred to 'physical, mental and moral health'[9]. Health in this period was at least partly measured against values, ideal (albeit functional) norms of well-being. Statistical measures of health were beginning to be

introduced in limited areas (especially mental handicap), but these were not at the centre of public health in this period.

A good indicator of the breadth of the conception of health in this period was the way officials saw their duties. A prominent Canada official described the duties of the Medical Officer of Health in the following way:

> He stands as the preventive officer of the people in all that relates to their health, and in the discharge of those duties must bring an intelligent knowledge of medicine into co-operation with law, education, engineering, architecture, sociology, agriculture in several branches, plumbing, and many branches of industrial life in so far as they have a bearing upon the individual and his environment (Hodgetts 1912c:253).

This broad conception of health collapsed back again as the parameters of public health began to shrink after about 1920. A primarily pathological conception of health, combined with a new statistical emphasis, came to dominate public health. Turshen (1977:57) wrote, "...various branches of public health, for example occupational health, nutrition and maternal and child care, were forced into the mould of the clinical medical paradigm."

It is important to stress that even at its broadest, health was still conceived in functional terms. There was no place for considerations such as self-defined well-being, self-realisation or individual and collective control over the conditions of life. Health was defined in terms of utility within the existing conditions in capitalist society rather than the potential for individual and social development[10].

At the pinnacle of the new hygiene, public health operated on the basis of a very inclusive, if still functional, definition of health. The expansion of the parameters of health to encompass such areas as productivity, family life and good citizenship was the product of a period in which the bounds of public health were expanding rapidly within social policy. The control of specific diseases was but one aspect of the broader project of national health, increasingly defined in terms of the physical and moral reproduction of the working class as wage labourers[11]. This broader project was eventually taken up by social work and welfare programmes together with state-funded medical care, reducing public health to a minor specialty with a narrower pathological and statistical conception of health.

2.1.2 The Sanitary Idea: Disease and Pauperism

The first major impetus for public health in the English-speaking world developed out of the work of Edwin Chadwick and the English Poor Law Commission.

> I must aver, that the sanitary measures now in progress had strictly and exclusively an official origin; that they arose as a consequence, tho' an indirect and perhaps accidental one, of measures directed by the government in 1832, namely the enquiry into the administration of the poor laws...(Chadwick in Flinn 1965:2).

The immediate genesis of the first public health measures was directly economic. Chadwick, the major policy-maker behind the New Poor Law, saw public health as a measure to reduce pauperism.

> Dominated solely by the actuarial problems of pecuniary profit and loss, Chadwick laid no claims to universal humanism but frankly admitted his narrow interests in

> keeping poor rates down (Finer 1952:157, see also Hodgkinson 1967:628-9).

Chadwick and his contemporary reformers believed that poverty could be reduced by eliminating blocks to the full participation of able-bodied workers in the labour market. The Poor Law Reform of 1834 aimed to eliminate blocks to labour market participation by dealing harshly with able-bodied pauperism (the principles of less-eligibility and the workhouse test) and promoting labour mobility (ending the principle of settlement).

Public health reform was conceived as an extension to this approach, eliminating conditions which generated ill-health and forced workers out of the labour market. The New Poor Law was to repress voluntary (able-bodied) pauperism while public health was to remove a major source of involuntary pauperism (disease) (ibid:147-8).

> [Chadwick's] turning to public health was an extension of the concern that led him to study poverty: the government expended too much money on poor relief. He hoped to reduce the number of state-supported widows and orphans by reducing the death rate among the working class. It was as straightforward as that (Tesh 1982:339).

Nineteenth century public health measures have often been portrayed as reactions to epidemics.

> Sanitary improvements were often made, not so much willingly and enthusiastically, as sporadically, in response to emergency conditions, especially to epidemics which drew attention to scandalous neglect and which made further delay impossible (Wohl 1983:173).

Yet epidemics in themselves did not necessarily pose problems from the point of view of the state. It was through the

poor law machinery that epidemics became a problem for the British state. This was true at a general level, where epidemics intensified the whole problem of health, poverty and pauperism by creating dramatic waves of death and depriving families of crucial wage-earners. At a specific level, epidemics created problems for Poor Law authorities, particularly when local guardians in London took measures against epidemics which were found to be outside of their legal powers (e.g. see Finer 1952:155).

The process through which public health became defined as a problem, then, inflected it with particular content. It was not, for example, the self-defined health of working class people that was the aim of public health policy. Rather, it was the health of workers as the basis for their self-reliance (i.e. independence from state relief) that was the central goal.

The way to achieve that goal was to reduce the incidence of specific diseases, such as cholera, typhus and tuberculosis. Chadwick (1965:76) sought the method for reducing these in his seminal report, in which he inquired as to, "...the chief removable circumstances affecting the health of the poorer classes of the population..." The 'removable circumstances' identified in the report were deplorable sanitary conditions, poor water supply, sewage disposal and ventilation. These were termed 'physical barriers to improvement'.

> The most experienced public officers acquainted with the condition of the inferior population of the towns would agree in giving first place in efficiency and importance to the removal of what may be termed the physical barriers to

> improvement, and that as against such barriers moral agencies have but a remote chance of success (ibid).

Sanitary conditions were identified as the 'physical barriers to improvement' on the basis of miasmatic theory, which linked the spread of diseases to atmospheric conditions associated with organic waste. The bad smells associated with excrement and rotting flesh were seen as disease agents. The aim was therefore to prevent the build up of these smells, through sewerage, decent water supplies (i.e. no smelly water), well-ventilated homes and workplaces, proper burial measures and similar environmental controls. Southwood Smith, a prominent contributor to early English public health, described the spread of disease through the miasmatic process:

> Wherever animal and vegetable substances are undergoing the process of decomposition, poisonous matters are evolved which, mixing with the air, corrupt it, and render it injurious to health and fatal to life...If provision is not made for the immediate removal of these poisons, they are carried by the air inspired to the air-cells of the lung, the thin delicate membranes of which they pierce, and thus pass directly into the current of circulation (cited Tesh 1982:337).

Miasmatic theory was based on the correlation between the living and working conditions of the urban poor and the spread of particular diseases. However, poverty in itself was not seen as the causal factor. In Chadwick's (1965:216) words, "The occurrence of sheer destitution is denied as a general cause of fever, not as a consequence." Rather, the explanation was sought in the condition of the urban poor. Chadwick (1965:98) cited the evidence of Dr. Arnott regarding the difference between the

horrible health of the poor in Edinburgh and the better condition of the rural poor:

> And, as a contrast, it may be observed here, that when the kelp manufacture lately ceased on the western shores of Scotland, a vast population of the lowest class of people who had been supported chiefly by the wages of kelp-labour remained in extreme want, with cold, hunger and almost despair pressing them down - yet, as their habitations were scattered and in pure air, cases of fever did not arise among them.

In contrast with the sparse, well-ventilated countryside, the town was a situation of intense waste production with limited circulation of air and water. This, out of all of the health-threatening conditions in the lives of the urban poor, was identified as the key to change, the fundamental 'removable circumstances'. In Chadwick's (1965:423) view, the removal of the threat of miasma could be best accomplished through urban engineering, with a particular emphasis on sewers and water supply.

In retrospect we can see that urban engineering was a useful solution based on a partial theoretical understanding. Public health historians regard it as 'noteworthy' or 'remarkable' that miasmatic theory served as an effective guide to action at all.

> Indeed, the remarkable fact about the work of the sanitary reformers in the first half of the last century is that, basing their proposals on a structure of erroneous theories about the transmission of communicable diseases, they nevertheless hit upon the right solution to their problem (Frazer 1950:40).

The implication of the retrospective amazement is that public health eventually moved from crude science dominated by economic and social considerations to genuine, apolitical

scientific medicine. Rosen (1958:209,224-5,259) linked the origins of public health at the level of economic and social policy to the weakness of medical science at the time. He attributed the secondary role of medicine in early public health to the fact that, "medicine had little real knowledge to contribute towards a solution of the major problems, which concerned the transmission of communicable disease" (ibid:225). The early sanitation was seen as setting in motion a structure which would later assimilate genuine science .

> Broadly speaking, what happened was that the founders of public health, accepting certain postulates of economic and social policy, established institutional forms that would serve later to implement more accurate and effective medical knowledge (ibid).

Yet the success of sanitarianism based on miasmatic theory is less remarkable if it is located in relation to state policy. Miasmatic theory served as the guide from a broad correlation (towns, poverty, dirt, disease) to a specific policy direction within the material and ideological limits of state activity. It was a useful policy tool, founded on a solid but partial empirical basis.

Miasmatic theory offered an approach to the health of towns which defined as problematic conditions (water, sewers, ventilation) which were appropriate objects of state policy at a time when poverty as such was not. Further, miasmatic theory was compatible with the requirements of international commerce. Ringer (1979:116) and Tesh (1982:327-38) both connected the dominance of miasma theory to these considerations. Miasmatic

theory was used to reject contagion theory (that diseases spread between people, or from animals to people) and the quarantine strategy which accompanied it. The quarantine of ships' crews or cargoes was costly and distruptive to commercial interests. As John Simon wrote:

> A quarantine which is ineffective is a mere irrational derangement of commerce; and a quarantine of the kind which ensures success, is more easily imagined than realised (cited Frazer 1950:96, see also Lambert 1963:68).

Anticontagionist miasmatic theory, then, might be seen retrospectively as bad medical science, but it was also effective state policy making.

> Dogmatic anticontagionism was nurtured to meet the needs of campaigns to change official policy: first to abolish quarantine and then to initiate programs of public hygiene...The precise mechanism of disease causation was of little interest to the sanitarian (Eyler 1979:100).

State policy science was oriented to action. Miasmatic theory was a powerful guide to the earliest sanitarians. The theory did not stand still, but developed through the nineteenth century through the engagement with practical questions. Miasmatic theory was modified in a direction that began to anticipate germ theory. The most prominent public health officials tended to hold positions which connected the spread of disease to some sort of disease agent (as in germ theory) which could operate only in certain environmental conditions (as in miasmatic theory)[12].

The old sanitarian public health saw considerable achievements in the condition of British towns. It arrived only belatedly in Canada, where the first full-time public health

apparatus (outside of emergency epidemic services) was not established until 1882 (in Ontario). The development of public health in Canada coincided with the bacteriological discoveries that would form the medical basis for the new hygiene (Sutherland 1981:361-2). Thus, the old sanitarianism in its purest form never really developed in Canada.

Nevertheless, the first Public Health Act in Ontario was modelled on the 1875 Act in England which represented the high point of sanitarian public health. Over the next twenty years, municipal sanitation under provincial direction flourished in Canada; first in Ontario, then in Quebec and later in other provinces (Defries 1940:15,67-9; Le Riche 1979:156-61).

Ultimately, sanitary measures could only go so far in improving the condition of the working class. The last quarter of the nineteenth century has been characterised as a period of consolidation, status quo, and ultimately impasse for British public health. This impasse resulted from having met the limits of sanitary reform, extending such programmes as far as they could go and yet facing new problems requiring different solutions.

> As long as the preventive endeavour was concerned primarily with the physical environment rather than with personal health factors, and until the bacteriological discoveries of the eighties and nineties had been fully assimilated health legislation could go no further (Lambert 1963:562).

One of the most important indications of the impasse of sanitarianism was the persistence of infant mortality despite sanitary reforms.

> But when perfect sanitation had done its utmost, there would still have remained a large number of infantile deaths due to non-sanitary causes and these, in the early years of the twentieth century, could only have been prevented through the education of the mother...by the provision of satisfactory substitutes for breast milk when the mother's supply failed or was insufficient, and by attention to the health and nutrition of the mother both before and after confinement (Frazer 1950:247).

The impasse of sanitarianism was one of the conditions for the breakthrough to the new hygiene in the early twentieth century. Of course, this impasse in itself does not explain the shift in public health theory and practice. New developments in medicine and more importantly in social policy around the turn of the century prepared the way for the new hygiene through the development of new goals and modes of intervention.

2.1.3 The New Hygiene: Physical and Moral Reproduction

The new hygiene became the dominant approach in public health around the turn of the century. The old sanitarianism had centred on removing the 'physical barriers' to working class health, the poor sanitary conditions linked to the spread of key diseases. The new hygiene focussed on education to promote all-round healthy living.

Ill-health was seen largely as a product of ignorance and indiscipline. Low standards of domestic cleanliness created routes of germ transmission. Inadequate knowledge was leading to poor nutrition, lack of exposure to fresh air and generally unhealthy ways of life. The failure of moral discipline threatened family life itself, creating an atmosphere of lazy self-indulgence, sexual transgression and cheap amusement.

The new hygiene traced these problems back to a perceived central core, the attitudes and competence of women as home-makers. The domestic labour of women was the foundation of family life, upon which rested the moral structures of society. The focus of public health shifted from the urban to the domestic environment; from physical to ideological barriers to health; and from a narrow focus on specific diseases to a broad emphasis on moral and physical reproduction. In the first report of the new British Ministry of Health, the Chief Medical Officer contrasted the new hygiene with the old sanitation:

> ...the progress of this form of sanitation and the advance of the science and art of Medicine have moved the centre of gravity from external matters to personal matters, and from sanitation to preventive medicine (UK.Health 1920:9).

This new hygiene focussed on 'the personal factor[13]' as opposed to the impersonal built environment. Hastings (1921:713) summarised the shift from the old sanitation to the new hygiene in the statement: "The pendulum has swung from the environment to the individual, from the objective to the subjective."

This was seen as a dramatic opening out in the parameters of public health. Public health was coming out of the sewers to become a major focus of social policy. The Secretary on the Ontario Provincial Board of Health asked of the wider profile of the new public health, "Does it not mark the beginning of the day when public health will become, in fact as well as in theory, the greatest of all public questions?" (Ont.PBH 1912:9).

The narrowness of the old sanitarians should not be exaggerated. The early sanitarians are often portrayed as obsessively focussed on plumbing, sewers and air circulation, to the exclusion of any other considerations. Their optimism about the impact of sanitary reforms caused them to neglect a wide range of social issues connected to health.

> Public health was never totally removed from broader questions of social engineering and general living standards. But for much of the century the enthusiasm and dedication of public health reformers enabled them to throw themselves into tasks without stopping to ask broader social questions (Wohl 1983:9, see also Frazer 1950:78).

In fact, many of the moral concerns of the new hygiene were anticipated in the work of Chadwick[14], Simon[15], Farr[16], and other sanitarians. Chadwick (1965:200) aimed to accomplish the "moral improvement of a population, by cleansing, draining and the improvement of the internal and external conditions of the

dwellings." Corrigan (1977:265-76) rightly emphasised the moralising project at the core of Chadwick's work.

Nevertheless, there was a substantial transition between the old sanitarianism and the new hygiene. A general concern with the moral condition of the working class was superseded by a more specific emphasis on the working class family as the locus of material and moral reproduction. Further, the new hygiene connected this moral project to a very definite conception of the national interest. The aim was to improve the operation of the working class family in the national interest through a personal approach aimed at changing individual habits and attitudes.

A. The New Hygiene, Individuals and Germs

In many ways, the defining feature of the new hygiene in contrast with the old sanitarianism was that it took a personal or individual approach to the problem of moralising the working class family. MacKintosh (1953:6) put it colourfully when he wrote, "...the sanitary idea began to be overhauled by the concept of the individual Mr. Harris or Mrs. Stevens, or of the Jones children." Disease transmission came to be seen as more a matter of individual behaviour in the micro-environment of the home, and less one of general sanitary conditions.

> The essential change is this. The old public health was concerned with the environment, the new concerned with the individual. The old sought the sources of infection in the surroundings of man; the new finds them in man himself (Hill 1920:8,1912:138)[17].

Hill saw this new focus on the individual as a more accurate method based on a better understanding of disease transmission. The new hygiene was founded on a firm scientific basis, representing the convergence of several disciplines and methods.

> The bacteriologist, the epidemiologist, and the vital statistician, sometimes working together, more often alone, in the dark and even at cross purposes, have nevertheless all reached the same point...(ibid).

Now that disease agents could be pinpointed, it was possible to develop specific measures to halt their transmission. In contrast, Hill scathingly portrayed the old sanitation as a crude, scatter gun approach.

> The old public health sought these sources [of infection] in the air, in the water, in the earth, in the climate and topography of localities, in the temperature of soils at four and six feet deep, in the rise and fall of ground-waters; it failed because it sought them, very painstakingly and exhaustively, it is true, in every place and in every thing <u>where they were not</u> (ibid, emph.orig.).

The new hygiene, in contrast, identified the one real route for disease transmission, "...those infective persons (or animals) whose excreta or other constituents or body contents enter the bodies of other persons" (ibid:8-9). Simple precautions could halt this transmission. Hill saw a rather simple division of labour in the implementation of these precautions.

> The government must strike at the sources and at the public routes of infection. The women must strike at the private routes. The men must support both methods for the sake of the women and children (ibid:32).

Public health, then, had to act directly through measures such as the quarantine of individuals where required, while

acting indirectly through 'the women' to ensure precautions on the private, domestic front. This was to be accomplished through a combination of education and supervision.

Hill established a very logical, coherent line between germ theory and the new individualistic orientation of public health. This line is often emphasized in public health history, where the change from sanitation to the new hygiene is often seen as beginning at the level of medical science. Sanitation was a limited approach to public health based on bad science. The new hygiene was a more sophisticated approach, based on the development of a solid bacteriological understanding of disease transmission.

Rosen (1958:332) described the new public health as the 'bacteriological era'. He saw bacteriological discoveries as the basis for a new truly scientific public health in contrast with the old sanitation.

> However, as bacteriologists identified the microorganisms responsible for specific diseases and uncovered their mode of action, the way was open for the control of infectious diseases on a more rational, accurate and specific basis (ibid).

Nor was this simply a retrospective view. The new hygienists conceived the change in similar terms. Bryce argued that public health had gone from 'inexact knowledge' to 'exact science' on the basis of the new bacteriological discoveries.

> ...the discoveries made during the past twenty years, regarding the causes of diseases, have, as already remarked, been the basis upon which exact regulations for the suppression of the several diseases have become more possible (Ont.PBH 1902:9-17).

At one level, it was obviously true that a less powerful explanation for disease transmission was superseded by a more powerful one. In itself, however, change at the level of medical science does not adequately explain this transition in public health. The new hygiene was not exclusively, or even primarily, concerned with the transmission of communicable diseases.

The following statement by Toronto's influential MOH is an illustration of the contradictions of explaining the new hygiene in terms of the rise of bacteriology. On the one hand, the development of the new hygiene was attributed to the advance of germ theory, while at the same time the control of communicable diseases was described as "but a fraction of the work" of public health:

> It seems but a short time since the principal activities of a department of health were the abating of nuisances and the cleaning up of back yards and lanes. Then with the advent of the science of biology came the new light on the germ origin of disease and how these germs were transmitted from one person to another, and how this transmission might be controlled, and now those who are able to visualize the possibilities of preventive medicine, as we see it today, fully realize that the control of communicable diseases constitutes but a fraction of the work of a modern department of health... (Hastings 1921:712).

Instructing on precautions against disease transmission in the homes of the infected was a tiny part of the work of public health in the home. It would be more accurate to state that germ theory was used as the scientific and rational foundation for the edifice of the healthy domestic regime, the importance of which went far beyond the parameters of halting disease transmission. The nurse who developed the first school nursing programmes in

New York City and Toronto, described the job of the school nurse in the following terms:

> To cure disease or remove physical defect is a necessary but incidental part of the work...The factors of greatest importance to the child's future welfare are wholesome food, proper clothing, personal cleanliness, physical drill and play, and plenty of fresh air in school and home (Struthers 1917:11-12).

This broad approach aimed at transforming life in the home was notable even in public health work specifically aimed at communicable diseases. Tuberculosis, for example, was a disease for which the agent of transmission was identified and the major routes of communication commonly accepted.

> The two chief sources of infection are the sputum coughed up by people suffering from consumption and the milk given by cows suffering from tuberculous udders (Smith 1920:539).

Yet in work around the prevention of tuberculosis, officials went far beyond the bounds of simply breaking these lines of transmission. This prevention was to be accomplished through the broad acceptance of the open-air regime, not only among patients and their families but broadly through the population. This regime included lots of fresh air and sunshine, proper food and clothing, good personal hygiene and a disciplined balance between rest and exercise[18]. This regime was seen as a crucial element in the development of a new, healthier generation.

> Open-air men and women bring up open air children, and so, granting this, by a slight effort of the imagination we can picture to ourselves a new generation springing up here and there throughout the country, a generation in every respect an improvement upon the present, stronger and healthier physically, morally and intellectually (Myers 1908:44).

Public health strayed far from the realm of germ-oriented precautions. The orientation towards the individual was not just a matter of effectively preventing the spread of germs from infected individuals. Rather the new hygienists aimed to promote a healthy domestic regime through personal contact, instruction and supervision. The public health home visitor was to be the, "guide, philosopher, and friend of the family" (Struthers 1917:8).

This personal supervision approach to the family was the key to the social work method. It initially developed in a number of smaller scale philanthropic endeavours, such as voluntary health visiting. It was systematised in the private efforts of agencies such as the Charity Organisation Society. In the late nineteenth and twentieth century, it was taken over by the state and generalised. The new hygiene can be understood as an important application of the social work method.

B. The New Hygiene and Social Work

The new hygiene of the early twentieth century involved a major shift in the mode of intervention employed in public health, linked to new analyses of social problems. Where the old sanitarian approach had emphasised changing behaviour through removing physical obstacles to improvement, the new hygiene stressed direct education and supervision aimed specifically at the labour of women in the home.

The impetus for this new approach came largely from social policy developments outside of the parameters of public health. MacKintosh (1953:6) described the state of sanitation following the 1875 public health act in the following terms:

> It had little effect, therefore, on the existing order of things because it lacked a forward programme...The real earth-shifting was done by the Fabians and other social reformers who saw the blight and were ready with remedies.

At the core of this 'forward programme' was the case work approach linked to a changing conception of the poverty problem. Beginning in the 1860's and 1870's, key poverty reformers (especially around the Charity Organisation Society) began to redefine poverty as a social problem. Rather than a single problem, indicated primarily by pauperism, they began to conceive it as two: the essentially unchangeable situation of the residuum who could not and would not work; and the changeable situation of the respectable and deserving who were capable of self-reliance except for some particular debilitating circumstance (sickness, old age, unemployment under certain conditions)[19].

Their work focussed around the question of rationalising charity so as to fine tune the assistance to the respectable, matching charity to the very particular needs of individual family units. In this way, it was hoped they could be prevented from falling into the residuum. This fall could result either from being driven by sheer poverty into the pauperised stratum, or from receiving too much of the wrong kind of charity which simply increased demoralisation and dependance[20].

Casework was conceived as the key to rationalising charity. It would serve the respectable through developing a detailed analysis of the requirements of each case (individual or family) over time. As Stedman Jones (1971:277) wrote, "...complete reformation could be the result only of close personal surveillance." Meanwhile, the residuum to be left to the Poor Law, which would necessarily be seen as punitive[21]. This personal case-by-case approach was absolutely central to the new hygiene focussed around home visits, individual inspection (in schools) and a range of programmes for establishing standards and then enforcing them through supervision. The legacy of this approach was clear in Newsholme's (1925:161) statement:

> Poverty ... is a complex, comprising many elements, variously combined in the production of the aggregate phenomenon; and each case of poverty must be studied individually if the correct diagnosis is to be made and the appropriate remedy applied.

This casework approach, linked in the first place to a very individualistic view of poverty (emphasising personal defects), was married in the 1880's to broader environmental theories[22]. Poverty was increasingly regarded as the product of social conditions rather than of failed will. This change was precipitated particularly by the political and economic crisis of the 1880's[23]. Corrigan and Sayer (1985:171) wrote that this crisis forced certain changes in the conception of reformers:

> It is now recognized that the moralization of the working class cannot be extended far enough, civilization cannot be 'forced downwards' fast enough because poverty is not simply a character defect.

The social conditions which were recognized as generating poverty were those of the city. Theories of urban degeneration linked poverty and related moral problems to the situation in industrial towns and cities:

> Poverty was no longer pauperism in disguise; the savage and brutalized condition of the casual poor was the result of long exposure to the degenerating conditions of city life (Stedman Jones 1971:266).

Social policy, then, become increasingly oriented to acting on the environmental roots of poverty. In early twentieth century Britain, this orientation included some embryonic benefits programmes offering direct assistance. More importantly, action on the environmental roots of poverty was seen in terms of promoting changes in the domestic environment through the casework method.

The most important application of casework in public health was through public health home visiting (public health nursing in Canada, health visiting in Britain). This became a central element of public health work. The major aim of this approach in public health was to establish standards for women's domestic labour and enforce them through household inspection. Hastings (1916b:1100) described the public health visiting nurse as, "...a home-maker, caring for the race from the prenatal state until it passes into the next cycle of existence." Rather than specific diseases, these home visitors focussed on the domestic conditions of the family:

> Today our public health nurse embraces the tuberculosis nurse, the child welfare, child hygiene, the sanitary advisor and the social agent. In other words, she

> specializes in the home and not in the disease...(Hastings 1916a:114).

This supervision of domestic labour was to be accomplished through a close personal relationship. "The school nurse who fails to get into intimate touch with the family, must confess she has failed in her first mission" (Struthers 1917:8). This personal relationship must be founded on knowledge of the community:

> As a teacher she is welcome because she has become known in the homes in their times of need and having shared the experiences of the home and the neighbourhood, she teaches in the language of their experience (Hastings 1916b:1101).

This was the social work method, emphasizing close personal contact and longer-term tracking as the key to improvement. This method was combined with the changing analysis of disease transmission to lay the basis for a new scientific domestic regime. Germ theory certainly guided public health officials in specific activities. More generally, it provided a scientific basis for a broad-ranging intervention into the home to foster a multi-faceted healthy domestic regime.

This regulation of everyday domestic life was not necessarily seen as an adequate response to the problem of poverty and illness on its own. Rather, it was generally conceived as one dimension of a programme which would also require broader material reforms. The social policy of this period will be discussed more broadly in the next section.

The period 1900-20 was an important moment of transition in public health and social policy. The rise of the new hygiene

corresponded to the development of new approaches to the regulation of the family centring around the social work method. Nor was this mere coincidence. The development of the new hygiene can be understood as one aspect of the reorientation of social policy in this period, reflecting the same methods, goals and theoretical premises.

This connection between public health and social policy should not be surprising. British public health emerged out of the first major transformation of social policy marked by the review of the poor laws. The next section will show the continuing link between broader shifts in social policy and changes in the theory and practice of public health.

2.2 Public Health and Social Policy

2.2.1 The Character of Social Policy 1900-20

The period 1900-20 saw the dramatic expansion of public health programmes in Canada and Britain linked to a significant departure in approach, the new hygiene. Public health was only one of the areas of social policy undergoing such growth and transformation in this period. This growth and transformation marked the beginning of a broad reorientation of social policy which would culminate in the development of the welfare state after World War 2.

The broad reorientation of social policy beginning in this period took place in all the developed capitalist countries, though not identically or at the same pace. Aglietta (1979:71-2,79-80) described it as the transformation from a regime of extensive accumulation to one of intensive accumulation. The account presented here draws on Aglietta as well as other theorists.

The cardinal features of this transformation were: 1) the intensification of labour in the workplace linked to the dominance of relative over absolute surplus value[24]; 2) the development of state-regulated industrial relations, including collective bargaining rights (combined with restrictions delimiting the realm of trade unionism) and a variety of regulations concerning minimum wages, health and safety and provisions for injury, severance or retirement[25]; and 3)the 'nationalisation' of the working class involving the strict

demarcation of the national working class through immigration controls combined with social policy to regulate the quality and quantity of that class. It is with the third of these that we are primarily concerned here.

The 'nationalisation' of the working class was a two fold process. On the one hand it involved the development of immigration controls to section off a national working class and control access to it. The segmentation of the working class into sections belonging to particular states did not reverse the internationalisation of the labour market. Rather, international labour mobility increased, but on terms established by national states according to a range of material and ideological factors (Harris 1980:37-39).

Corresponding to the delimitation of a national working class was an increase in prescriptive state supervision over its reproduction. Earlier social policy had been primarily proscriptive in character, suppressing alternatives to wage labour and prohibiting or constraining a wide range of working class activities[26].

Prescriptive social policy aimed to shape and improve working class life through education, benefit programmes and supervision. It developed in two stages (allowing that this is a schematic sketch)[27]. The first stage (very roughly 1860-1920's)[28] involved a new conception of poverty as the product of the physical, mental and moral degeneration of the working class under urban industrial conditions. No longer was poverty simply

regarded as a failure of the individual will. The programmes developed to counter this degeneration emphasised the moral improvement of the working class family through a range of supervisory measures aimed largely at the regulation of women's domestic labour. Direct material provision was still regarded as highly suspect, to be given only if accompanied by extensive instruction and moral leavening.

The second stage in the development of supervisory social policy centred on universalistic social insurance programmes, the modern welfare state introduced primarily during the post-World War 2 boom. The poverty problem was recast, with the primary focus on temporary impediments to the self-reliance of the normally employed due to economic cycles, ill-health or family separation. This was conceived as an economic problem focussed on the cyclical nature of capitalist prosperity rather than a social problem of demoralisation as it had been earlier. The problem of the residuum who could not or would not work continued to be regarded largely in social/moral terms.

Family-oriented social policy did not simply vanish with the development of universalistic social policy. The nuclear family structure was implicit in the structure of social insurance programmes (e.g. in definitions of wage-earners and dependents) (Land 1976:258-60). The programmes aimed specifically at the regulation of domestic labour (such as home visiting and domestic education) tended to continue though they became less visible as they were integrated into the taken for granted structure of

everyday life. These programmes were complemented (and to some extent superseded) in the regulation of domestic labour by the establishment of norms for mass consumption and the rapid development of cheap household commodities beginning in the 1920's but really taking off after World War 2 (Aglietta 1979:151-4,171; Hayden 1981:265-9, Barret & McIntosh 1982:63-4).

The period 1900-20, then, was a transitional moment in the development of prescriptive social policy, preceded by primarily proscriptive regulation and succeeded by the universalistic welfare state. In this period, the parameters of social policy were extended to encompass a range of new problems and conditions. However, the modes of intervention which marked this period, primarily concentrating on supervision through social work methods and the cautious provision of direct assistance in specific circumstances, proved inadequate in dealing with these new problems and conditions.

Public health based on the new hygiene played a prominent role in this transition towards prescriptive social policy. It was centrally involved in both aspects of the 'nationalization' of the working class, the creation of boundaries through immigration controls and the regulation of self-reproduction through the family system using social work methods. The new hygiene combined a perspective for defining new problems and methods for attempting to solve these.

In the long run, however, the development of prescriptive social policy towards the welfare state would leave public health

a minor area of specialty within medicine. In the period of proscriptive social policy, sanitarian public health had been prominent as the 'positive' side of the campaign against pauperism (Finer 1952:147). It offered a means of improving health through shaping the environment without direct assistance to individuals which might generate dependence.

Around the turn of the century, the new hygiene developed as an important aspect of the shift towards prescriptive social policy. However, public health contributed little to the ultimate form of the welfare state. The problems that the new hygiene had defined in broad social and moral terms were redefined in more specific economic and medical terms. The solution of state supervision through home visiting remained but a minor feature of regulation which centred around social welfare benefits and state-funded medical treatment.

> Commencing as a purely Public Health movement before the close of the century, the new conception of the duty of the community towards its poorer members widened until in the course of years it embraced the manifold activities of the modern state in the direction of Personal Hygiene, Social Insurance and Social Medicine (Frazer 1950:239).

Public health was ultimately fragmented and marginalised in this second stage of prescriptive social policy. Ironically, it was at its moment of triumph (marked in Canada (1919)[29] and Britain (1919) by the creation of Ministries or Departments of Health) that the marginalisation of public health began. From a wide-ranging vehicle for social reform dominated by ameliorative environmental social theory, the parameters of public health narrowed to those of preventive medicine conceived as a minor

specialty within medical theory and practice. Marks of this change included the exclusion of lay members from the Canadian Public Health Association, the increasingly technical content of journals, the developing tendency to define the early treatment of disease as a major form of prevention and the limited achievements of the new Health Ministries in terms of new programmes or substantial expansion before World War 2 (Bator 1979a:346-8;Newsholme 1925:73,256-9; McGinnis 1980:39).

2.2.2 The New Hygiene in the Era of Imperialism

A. The Rhythm of Reform

The schematic model sketched out above plotted the broad trajectory for the reorientation of social policy over a period of perhaps sixty years. This was neither a single rupture nor a steady, gradual change. Rather, it was a change which proceeded in fits and starts, impelled largely by the rhythm of the class struggle. This change occurred through a process in which policy-makers defined and attempt to solve social problems in response to developments in society.

Public health developed initially as a state response to the problem of urban poverty. A number of factors were required to make urban poverty a problem for the state. Most obviously, permanent public health programmes only developed once the objective conditions of concentrated urban poverty existed on a sufficiently large scale[30]. These conditions appeared first in

Britain, the home of the industrial revolution. In Canada, the first wave of industrial urbanisation began in the 1880's

But these objective conditions in themselves only became problematic for the state through a process involving other political and ideological factors. The definition of new problems (or the redefinition of old problems) by state policy-makers was a response to developments in society which threatened or impaired the economic, social and political framework of the nation. These developments ranged from increased rivalry in international markets to the introduction of new labour processes in production, from the concentration of capital to labour militancy. The most important of these in determining the rhythm of social policy innovation was the level of working class confidence, organization and combativity.

Capitalism by its nature generates a wide range of obstacles to the well-being and orderly reproduction of the working class, whether in the form of poverty, unemployment, recurrent housing crises, inadequacies in the wage system, or various environmental hazards. If workers always accepted their conditions of life, these obstacles in themselves would not become problems for the state. In fact, if such permanent acceptance of capitalist conditions existed in the working class, there would be no need for the state to exist.

> If there were no class struggle, if the working class were willing to submit passively to their subordination to capitalist social relations, there would be no state (Clarke 1983:119).

The development of the state and social policy is impelled primarily by working class resistance at some level or another rather than by the existence of objectively-given social problems. Kay and Mott (1982:96) thus described state administration as an "archaeology of working class oppositions."

> Administration is working class power post factum, working class political victories captured and formalised at their moment of triumph (ibid).

This is not to argue that there was a straightforward mechanical relationship between working class mobilisation and innovations in social policy generally or public health specifically. State policy innovations represented attempts to solve political problems posed most sharply by working class struggles. These innovations, however, tended not to be straightforward concessions to working class demands.

> A process of transformation, reformulation and displacement takes place between the claims springing from exploitation and the resistance to it - in a word, from the working class condition - and state policies supposed to meet the needs of the public (Topalov 1985:259).

Public health, then, can be conceived at a general level as one aspect of the displaced state response to working class self-organisation and mobilisation. This process of transformation and displacement produces a situation in which the correspondence between working class mobilisation and state response is not exact. Nevertheless, the greatest periods of innovation in public health and social policy tended to correspond to periods in which the working class movement was creating itself as a problem through organisation and activity.

Public health first developed in Britain in a period of sharp social conflict which culminated in the Chartist movement. The period 1830's and 1840's saw the first transformation of British social policy, innovations which included the review of the Poor Laws, the introduction of factory legislation, the development of national policing as well as the first public health legislation. Public health originated as a response to working class resistance and social conflict, one of the ways to prevent (or minimise) disorder in the future[31]. The concern for social order was present in Chadwick's (1965:266-68) report, particularly around the question of disease killing off older and more stable workers leaving only young hotheads predisposed to protest and strife.

The periods of rapid innovation in British public health after the initial reforms were also linked to social upheaval. The theoretical foundations for the new hygiene were established largely during the 1880's, when old certainties about social policy were thrown out by the threatening combination of unemployed protests and labour organisation[32]. The new hygiene grew rapidly on these foundations during the period of the 'labour unrest' in the early 1900's[33]. The first Ministry of Health was formed in 1919, a peak year of class struggles.

A similar pattern of development occurred in Canada, beginning somewhat later. The first wave of mass working class organisation in Canada took place in the 1880's. The Knights of Labour organised between 20 and 40 per cent of employed workers

in Ontario's industrial urban centres before going into decline after 1886 (Palmer 1983:103). This wave of organisation not only produced a growing number of strikes, but also the first sustained and systematic attention to industrial relations by the Canadian state in the form of the Royal Commission on the Relations of Capital and Labour (1887)[34].

Nor was it only industrial relations that received serious attention in this period. The whole field of social reform and state social policy opened up. Cook (1985:107) linked the birth of the social gospel (the orientation of Christian churches to secular moral and political reform) in Canada to the social thought around Knights of Labour meetings and publications. This was a period in which the old certainties about poverty being the fault of the poor began to give way to new thinking about the need for reform.

A social reform movement began to take shape, linking women's organisations, middle class reformers, churches and labour representatives. Philanthropists, thinkers and policy-makers were beginning to reconsider the welfare question, based on an increasing doubt that the poor were responsible for their own poverty (Wallace 1950:367). This rethinking was exemplified in the following statement from the Royal Commission on the Prison and Reformatory System of Ontario (1890) calling for wider state action to prevent or remove social problems:

> The example of Great Britain proves, most conclusively, that much more can be done by the State and by associations to save those who are in danger, and to raise those who have

fallen, than has yet been attempted in this province (cited Splane 1965:56).

This period saw the rudimentary development of a conceptual and administrative framework for state social policy in Canada. Ontario passed legislation in 1882 and 1884 to become the first province to establish a permanent, staffed Board of Health responsible for legislation based on the consolidated British legislation of 1875. Other new social policy legislation introduced in this period (particularly in Ontario) covered compulsory education, factory conditions, the care of neglected and dependent children and employers' liability in workplace injuries (Guest 1980:31,40; Splane 1965:10,53-4).

The new hygiene developed and spread against a background of increasing working class organisation and militancy in Canada[35]. The spread of public health was one of the social policy solutions attempted by the Canadian state to the social problems of this period. As in Britain, this period peaked with a great strike wave in 1919, the year of the first ministerial-level national department of health.

This is not to argue that working class protest was the only problematic shaping public health programmes. At times, public health programmes were indeed promoted specifically as responses to working class unrest. This was relatively rare however, generally only in periods of particular turbulence[36]. Rather than a specific response to the problem of working class militancy, public health should be seen as one aspect of the social policy response to the 'working class question', a

question posed most sharply by the struggles of workers themselves. The parameters of this question varied through the development of capitalism, but at its broadest included the quality, quantity and motivation of the existing working class as well as the system of generational replacement.

B. The National Working Class in the Age of Imperialism

The period 1900-20 was marked by the intensification of international economic and military competition which culminated in the First World War. Many sources have connected the rise of the new hygiene and related social programmes to the sharpening of imperialist rivalries. These sources identified the relatively dismal record of the British side in the Boer war and the significant problems indicated by the proportion of military recruits rejected as unhealthy as triggers for social policy innovation in Britain[37].

The connection between public health and imperialist competition did not materialise suddenly in the wake of the Boer War. Chadwick (1965:251-2) explicitly raised the connection between working class health and the productivity of labour, noting that British workers compared favourably to their European counterparts. Further, he specifically raised the question of army recruitment:

> Indeed, so great and permanent is the deterioration that out of 613 men enlisted, almost all of whom came from Birmingham and five other neighbouring towns, only 238 were approved for service (ibid).

This general concern sharpened and moved to the centre of public health theory and practice in the period 1900-20. The literature of the period abounded with references to the condition of the working class as the central factor in the position of the nation in economic and military competition (see below, pp.126-31). This was true both in the centre of the Empire (Britain) and in a more peripheral dominion (Canada).

Intensifying military and economic competition, in combination with the self-organisation of the working class, led states in this period to move towards the nationalisation of the working class. Steps were taken to delimit a national working class through immigration controls and related mechanisms and to increasingly supervise the reproduction of that class. In Canada and Britain in this period, the goal of nationalising the working class in a period of intensifying global competition was often described in terms of building an 'imperial race'.

Lord Rosebery prominently articulated this conception of the imperial race[38]. In 1900, he stated in a speech:

> An Empire such as ours requires as its first condition an imperial race - a race vigorous and industrious and intrepid... Remember, then, that where you promote health and arrest disease, where you convert an unhealthy citizen into a healthy one, where you exercise your authority to promote sanitary conditions and suppress those which are the reverse, you in doing your duty are also working for the Empire (Rosebery 1921:250).

This conception of Empire-building through the regulation of reproduction was highly influential in British and Canadian public health in this period. Nor was this limited to the

British Empire. A similar orientation was present in German public health in this period (Lilienthal 1986:66-7).

The whole question of forging a national working class in the age of imperialism was nonetheless rather different in Canada and Britain. Canada during this period was accumulating a working class largely through massive immigration, including for the first time a significant proportion of immigrants who were neither British nor American. Social problems were often seen as old world baggage brought over by immigrants rather than (or as well as) products of domestic social conditions. The contradictions of reproducing a fragmented working class which was at the same time an 'imperial race' were at the core of Canadian social policy in this period. These issues are discussed in chapter 3 below.

Immigration controls were also an issue in Britain in this period, but they figured far less prominently in considerations of social policy and public health. British policy-makers in this period tended to accept that the roots of social problems lay at least largely in domestic social conditions. In Britain, this question of an imperial race tended to revolve largely around the relationship between the ruling and ruled races of the Empire[39]. Further, the question of international competition was more sharply articulated at the centre of the Empire than in the Canadian dominion.

2.2.3 The New Hygiene and Theories of Race Degeneration

The question of the imperial race was related to social policy priorities through theories of race degeneration. These theories focussed on the idea that the quality of the national working class was deteriorating physically, mentally and morally due to the impact of urban conditions. There were many versions of this theory, diverging particularly around the questions of the primacy of moral or material reform and the relative importance of environment and heredity in causing degeneration.

In the 1880's and 1890's, degeneration theory moved to the centre of the social reform movement in Britain. It was an important ideological element in the reorientation of social policy which began in that period.

> The theory of 'degeneration' switched the focus of enquiry from the moral inadequacies of the individual to the deleterious influences of the urban environment. It thus prepared the middle class public to see chronic poverty as an endemic condition of large masses of the population, rather than as a product of exceptional misfortune or improvidence on the part of isolated individuals (Stedman Jones 1971:313).

Public health was one of the social policy areas in which degeneration theory played an important role. The idea that urban conditions were causing a deterioration in the physical, mental and moral condition of the working class was not a new one in public health. Chadwick linked 'a perpetual tendency to moral as well as physical deterioration' to the presence of 'noxious physical agencies' (i.e. bad sanitation and its miasmatic consequences) in towns.

> The facts indicated will suffice to show the importance of moral and political considerations, viz., that the noxious physical agencies depress the health and bodily condition of the population, and act as obstacles to education and to moral culture; that in abridging the duration of adult life of the working classes they check the growth of productive skill, and abridge the amount of social experience and steady moral habits in the community: that they substitute, for a population that accumulated and preserves instruction and is steadily progressive, a population that is young, inexperienced, ignorant, credulous, irritable, passionate and dangerous, having a perpetual tendency to moral as well as physical deterioration (Chadwick 1965:268).

Views of urban degeneration or deterioration can also be found in other prominent sanitarians, such as Simon, Farr and Nightingale[40]. These early views tended to connect deterioration specifically to the impact of sanitary nuisances. In contrast, later theories of degeneration tended to problematise a wider range of urban conditions; to more heavily emphasize the perceived hereditary aspects of deterioration; and to display a sharper conception of race in the context of intensifying imperialism.

A. Nature, Cities and Deterioration

The detrimental impact of urban conditions on health was a recurring theme in public health. It was pervasive in the writings of new hygiene, where the unnatural organisation of city life was commonly seen as the basis of social disease.

> During the past fifty years both in America and Europe there has been a too general movement of rural peoples to urban centres, and the resulting congestion of population in towns and cities has had a demoralising effect on public health (Struthers 1917:5).

The natural life for humans was life on the land. Humans were born naturally suited to rural life.

> The normal child is born with inherited tendencies for the life his or her ancestors lived for ages and ages - the life of the semi-naked hunter, of the fisher and the shepherd. Now to bring this child, an immature hunter, fisher and shepherd to maturity, we must remember that from his point of view our conditions are artificial and unnatural... (Sherrington 1903:29).

Public health officials were certainly not unanimous in identifying the specific features of urban life which threatened human well-being. The lack of fresh air and water, the pace, the overcrowding, the lack of exercise and the alienation from nature were all among the 'evils' of city life[41]. At the same time, cities were not seen as necessarily producing a degenerative environment[42].

> At the outset we must guard against the too general and broad generalization that in urban populations there necessarily must follow in a public health sense a degeneration both physical and moral (Ont.PBH 1904:105).

The aim was not, therefore, to halt the growth of cities but to regulate urban life so as to remove the worst obstacles to health. In the nineteenth century this was to be done through the improvement of sanitation. In the early twentieth century, programmes began to aim in two directions: at restructuring the urban environment and at improving the life-skills of individuals.

> To conserve the race we must, by scientific town-planning, improve the material environment of the city-dweller, and, by physical training in our schools secure as fine a bodily stamina for the city as for the country child (Conservation of Life 1914:31).

The concentration on the dangers of urban life had been a feature of public health from the outset. The theory of race degeneration was distinguished from earlier views in its stress on the cumulative nature of the damage of city living over generations. In 'classical' degeneration theory, this progressive damage was clearly hereditary, transmitted between generations[43]. This view was typified in the following statement from an article on physical exercise in a public health journal.

> That the result of living in a great city like London consistently from decade to decade is that the race dies out before the fourth generation (Robertson 1904:75).

Public health officials did not necessarily buy all aspects of the theory. In fact, the view that the condition of the working class was getting cumulatively worse tended to be rejected by the most important officials and enquiries. The Interdepartmental Committee on Physical Deterioration, struck specifically to investigate physical deterioration and its remedies, found early on that there was no data to support the thesis of cumulative degeneration, and little support for it among the evidence they amassed.

> It may be as well to state at once that the impressions gathered from the great majority of the witnesses do not support the belief that there is any progressive deterioration (ICPD 1904:13)[44].

The next sections will examine some of the debates around theories of race degeneration within public health. These debates moved to the centre of public health theory, providing an important theoretical foundation for the new hygiene. The immediate catalyst of perceived imperialist crisis[45] forged a new

public health out of theories of race degeneration, germ theory, the social work method and the initiatives of local officials.

B. Degeneration: Hereditary or Environmental

It was not 'classical' race degeneration theory which moved to the centre of public health in the early twentieth century. Rather, in public health circles 'race degeneration' was used to describe a perceived general crisis in working class reproduction. The precise cause of this crisis was debated within public health circles, though officials tended to explain it in terms of some combination of environmental conditions and hereditary transmission with the emphasis on the environment.

'Classical' degeneration theory was an analysis of mental deterioration, based on the view that characteristics acquired during a lifetime could become hereditary, passed on through the generations. Nordau (1968:16), a nineteenth century German advocate of degeneration theory, traced its origins back to writings of Morel in Paris in the mid-1850's. Morel's definition of degeneration stressed the hereditary transmission of acquired mental conditions.

> The clearest notion we can form of degeneracy is to regard it as a morbid deviation from an original type. This deviation, even if at the outset it was ever so slight, contained transmissible elements of such a nature that anyone bearing in him the germs becomes more and more incapable of fulfilling his functions; and mental progress, already checked in his own person, finds itself menaced also in his descendants (cited ibid).

By the early twentieth century, the view that people could pass on characteristics acquired through experience was at the

very least regarded as highly debateable, as Darwinian evolutionary theory, stressing the natural selection of random mutations came to dominate the field[46]. Further, a theory that in its classical form had been used to analyse the mental condition of the upper classes[47] had become a broad perspective on the physical, mental and moral condition of the working class. The theory of race degeneration in public health had changed dramatically from its classical namesake.

It would, in fact, be inaccurate to speak of a single theory of race degeneration in public health, as opposed to a range of views about a perceived crisis in working class reproduction. The current of opinion closest to classical degeneration theory was the one that stressed the hereditary dimensions of the reproduction crisis, the eugenics movement.

Committed eugenists formed a small minority current within public health[48]. Public health eugenists saw race degeneration primarily as a problem of biological reproduction: the wrong types were producing plenty of offspring, while the right types were becoming less and less prolific. The core of the eugenic programme was the regulation of biological reproduction so as to stop the wrong types from having children. A leading British eugenist, described the system of unregulated reproduction in a public health journal in the following words:

> ...the present system whereby the idiot, the feeble-minded, the drunkard, the habitual criminal, the professional pauper, the ordinary wastrel and the diseased have the same right to propagate their species as anyone else (Barr 1911:707).

The aim was to institute some form of 'artificial selection' in human reproduction, along the lines of animal breeding. Shortt (1912:307)[49] wrote, "Surely it is of more importance to have some regulation of grade in our human stock than in our horses and cattle." A broad scheme of 'artificial selection' was seen as unworkable in public health circles, even by some who were sympathetic to the goals.

> Now if moral considerations permitted, we could unquestionably improve the human race by applying the methods of the cattle-breeder. But, of course, they do not permit (Horgan 1906:342).

General regulation of biological reproduction was seen as a threat to the moral foundation of the family system. A Public Health Journal Editorial (1912:198) stated in rejecting broad eugenic regulation, "But let us not forget moral beauty, character, intellect, human worth and nobility."

Further, eugenics in its broadest form cut against the whole direction of public health reform. Environmental improvement aimed at the urban poor was seen by hard-core eugenists as interfering with the survival of the fittest by creating a nurturing environment for the least fit[50]. Newsholme (1910b:9-78) devoted considerable effort in his first report on infant mortality to refuting the eugenist argument that saving infant lives would interfere with natural selection:

> An adverse environment does not act merely like a breeder of dogs who selects the best from the litter, to be nurtured with every care, and destroys the weaklings at once; on the contrary, while it kills some, it will weaken many of the survivors also (ibid:78)[51].

Most importantly, eugenics simply did not provide a useful guide to action in the improvement of working class health. The terrain on which public health officials could act to achieve tangible improvements was that of the environment.

> If the hereditary possibilities are to a very large extent beyond our control, all the more imperative is the call on us to so better the conditions of life as to enable men and women to make the very most of existing hereditary possibilities (Morgan 1906:345).

Hastings (1919:106) summed up this pragmatic challenge when he wrote, "...the moment conception occurs the possibilities of eugenics end...Where eugenics end, euthenics [i.e. environmental reform] must begin." This was not a thorough refutation of eugenic reasoning, but rather a practical challenge to the utility of the eugenic programme in public policy combined with a definite rejection of particular directions in eugenic thought (e.g. in the area of infant mortality). Even committed eugenists in public health circles conceded the importance of environmental reforms.

> Those, like myself, who attach a high value to heredity, are not likely to neglect the proper consideration of the environment in the evolution of the race (Barr 1911:719).

The general tendency in public health was to stress the environmental causes of degeneration. Hodgetts (1912:544), for example, wrote of poor housing in bad urban conditions, "...owing to these evil environments, disease, crime, immorality and poverty resulting in physical degeneration inevitably result."

The marginalisation of hard-core eugenics within the public health framework went along with the broad acceptance of

selective eugenic programmes. This was particularly true in the area of mental handicap, where the prevention of biological reproduction was regarded as an absolute necessity. The strict control of reproduction in specific areas was to be combined with general education so as to encourage people to voluntarily reproduce along eugenic lines. A Public Health Journal Editorial (1912:335) exemplified this selective eugenics approach:

> We can eliminate the criminal, the insane and the hopelessly diseased by inhibiting their reproduction, and we can so educate children that instead of thinking themselves bound to follow a hasty impulse or an immature fancy, they will enter upon marriage deliberately, and with a full purpose and hope, on the grounds of ascertained facts, and with a knowledge of urgencies, of leaving behind offspring that will be mentally and physically superior to their parents.

The argument that people who were mentally handicapped needed to be segregated in institutions to prevent them from having children was generally accepted in public health[52]. The need for some sort of education to prepare people to make eugenically-sound marriage decisions was also accepted[53]. Beyond this, the emphasis in public health theory and practice was on the environment.

It would be a mistake, then, to attempt to slot public health theories of race degeneration as either eugenic or environmentalist. While the dominant tendency in public health was to lean towards environmental reforms, eugenic arguments and solutions were widely used in specific policy areas. In this period, public health officials did not tend to view eugenics and environmentalism as opposite poles in a debate, but as complementary theories each with specific areas of application.

Race degeneration was historically and technically[54] a theory of hereditary transmission, but in early twentieth century health it denoted a crisis in working class reproduction with environmental and hereditary dimensions.

C. Environmentalism: Moral or Material

Public health officials agreed broadly about the fundamental conditions underlying the crisis in working class reproduction they understood as race degeneration. These conditions were summarised rather well in a statement by W. Struthers (1913:67):

> Poor housing conditions, lack of light and ventilation, uncleanliness, ignorance of proper care of the body and of the laws of health, unwholesome and improper food and drink, the prevalence of venereal and other diseases are rapidly producing a degenerate race.

They tended to see these conditions as primarily the product of the ignorance in the working class.

> There are numerous factors that go to make up the large death rate of our slums, of which ignorance is probably the most potent (Hastings 1917:88).

They were not necessarily naive about the dire material circumstances of working class life. Some officials stressed the priority of material reforms.

> The education of those people is essential, but moral instruction must go hand in hand, and, in order of time, material reform comes first. Otherwise the higher ends of humanity are unattainable (Conservation of Life 1919:31).

Even advocates of the primacy of moral reform conceded that

material conditions were a pressing problem.

> Although I am profoundly convinced that lack of moral grit is at the root of most of our social problems, and is largely responsible for the misery and social evil which we see around us, I am aware that it would be absurd to ignore or to undervalue other contributing causes, economic, physical and environmental (Harris 1911:813).

Despite this recognition that material conditions were at least a 'contributing cause' to the problems of working class life, the general tendency within early twentieth century public health was to stress education as a remedy for ignorance. Instruction was to be the primary mode of public health intervention, and material reforms were to be offered only on the condition that they were accompanied by education[55].

There were three central reasons for moral reforms to be prioritised over material reforms in the theory and practice of the new hygiene. The first was very practical. Public health officials simply did not have the jurisdiction to introduce sweeping material reforms such as assisted housing. Certainly there were some exceptions to this, particularly in the areas of school meals and medical treatment in England[56]. Generally, though, officials could only be advocates as opposed to initiators of material aid programmes due to the delimitation of turf linked to the increasing fragmentation of state services.

Secondly, the absolute priority of public health was to promote the self-reliance of the family. Officials continued to fear that direct assistance would generate dependence. The general principle for material assistance, as stated clearly by

Newsholme (1925:165) was to offer only that aid which would, "conduce to early restoration to economic and social efficiency."

This was obviously a difficult principle to operationalise. At the most general level, it was a guideline for caution and the rigid combination of material assistance with supervision. Swain (1903:126-7) argued that slum reform, "must be on two lines, reconstruction and firm control." The material problems of the working class could not be solved one-sidedly through providing assistance, which would only perpetuate the downward cycle of dependence and demoralisation.

Thirdly, the emphasis on ignorance was linked to a social reform perspective which tended to idealism[57]. The moral condition of the working class was seen as the absolute key to regulated self-reproduction. Even material reforms were understood primarily as requisites for moral improvement.

> Everything we do to improve the physical conditions will make it easier to improve the moral conditions, so long as, in both respects, we do not encroach on the freedom of the individual (Conservation of Life 1919:31).

Ignorance, in the double sense of lack of information and ethical backwardness, was seen as the central obstacle to working class self-improvement. There were different ways to remove that obstacle, including direct provision, but the aim of the exercise remained largely instructional.

In public health circles, then, race degeneration was seen primarily as a problem of ignorance, though direct material provision was not excluded as part of the solution. The most damaging form of this ignorance was inside the home.

> The ignorance among the poor of household management and of the principles of hygiene is responsible in no small measure for their high preventable mortality, their inferior physique, their intemperance, and their poverty (Kenwood 1905:139).

The problem of ignorance inside the home primarily concerned the skills, commitment and discipline of the mother. In the past, instinct and unscientific knowledge passed through the family had been an adequate foundation for motherhood. That was no longer true.

> In modern life mother instinct is an inadequate guide for the rearing of children into capable men and women. The mother needs the assistance of those with special knowledge and teaching aptitudes (L.Struthers 1917:239).

The ignorance of women in the home was largely the product of the perpetuation of unscientific folk knowledge through the unregulated family system.

> It would appear that the majority of people when considering the physiology and hygiene of their own bodies, when considering their health or ailments, leave the realm of common sense to enter a mysterious realm of magic, folklore, and superstition (W.Struthers 1914:68).

Through science, public health could, "...confirm, extend or replace what our grandmothers have been preaching and inducing us to practice" (Wesbrook 1912:491)[58]. The family was to be cleansed of superstition and placed on a scientific foundation under the supervision of the state.

But it was not only lack of knowledge and the prevalence of folklore that stood in the way of working class improvement. It was also a pronounced tendency towards self-indulgence which was finding expression in different aspects of life. This tendency, described by the ICPD (1904:41, cited below p.248) as "the taint

with which the love of amusement was infecting large sections of the population, especially amusement in the form of cheap excitement..."

The seeking after cheap amusement was linked to the development of cities and the breakdown of traditional morality. Bryce (1914:215) argued that modern cities created, "...an atmosphere where gratification of the senses is the natural occupation of society." This was the ethical dimension of ignorance.

Ignorance, then, was a condition of the urban environment, where old folk knowledge was no longer an adequate guide to home-making; where traditional morality was replaced by the quest for cheap sensation. It was marked by a combination of wrong or insufficient knowledge with a failure of moral standards. This ignorance was the most single important cause of the degeneration of the race.

This explains the emphasis public health officials placed on mental handicap. Ignorance was seen as assuming its most concentrated form in the case of people who were mentally handicapped (or 'feebleminded' in the language of the times). Thus the condition of mental handicap was seen as a major cause of a constellation of social problems.

> Social problems such as poverty, immorality, vice and crime are deeply rooted and chronic. Modern society and business methods have been unsuccessful in solving them because feeblemindedness has often been the underlying factor (Keys 1918:99).

The lack of knowledge and moral self-control which were the general marks of ignorance were assumed to take particularly sharp form in the condition of people who were mentally handicapped. The presumed growth in the population of the mentally handicapped under urban conditions was one of the crucial indicators of race degeneration.

Ignorance was connected not only to broad social problems, but also to specific diseases. Tuberculosis, infant mortality and venereal diseases were all seen as rooted in conditions of ignorance, to be prevented primarily through instruction (see below pp.194-98). This instruction was to be accomplished through the use of social work methods in the home.

The theory of race degeneration, then, informed public health work in a wide range of areas. At the core of this theory was the ignorance of the working class, produced by urban conditions. While material solutions to this ignorance were not excluded, the major focus was on the use of social work techniques of supervision to raise the level of skills and discipline, particularly in the area of women's domestic labour. A broad-ranging theory of social reproduction was connected to very pragmatic solutions[59].

2.2.4. The New Hygiene and Social Policy in Canada and Britain

Public health was in many ways an international movement. International Congresses on a variety of subjects brought together officials from many nations to generalise knowledge and exchange news about practical developments. This diffusion of ideas was important in the development of public health, yet the form of public health programmes in particular nations was connected to the specific social policy priorities of the moment.

The social policy priorities of individual states (with similar levels of development) at a moment in the history of capitalism will often be substantially similar given the conditions of competition in the world market. Yet social policy also reflects the history of class struggle, peculiarities of economic development and other specific national patterns. Social policy can be reduced neither to national developments nor to international patterns, but reflects the particular playing out of national circumstances in the context of world developments[60].

Given the international diffusion of public health ideas and the international linkages of social policy, it should come as no surprise that the new hygiene in Canada and Britain was substantially similar. This was particularly true as Canadian public health had developed later, patterned largely on British developments to that point[61]. The development of public health as social policy began in the period 1830-50 in Britain and during the 1880's in Canada. As the impulse for social policy

developed later in Canada, policy-makers did not have to start from scratch, but could borrow theoretical and practical approaches from Britain (and the United States)[62].

These approaches were applied as they fit Canadian conditions, in combination with new methods developed as necessary. In the period 1900-20, the gap between Canadian and British conditions was much narrower than it had been in the period of the birth of modern sanitation. There were substantial similarities, though also important differences, in the contours of the working class question in Canada and Britain in this period.

At the most general level, Canada and Britain in the period 1900-20 were both in the first stage of the development of prescriptive social policy. Environmental and eugenic theories of race degeneration dominated the conception of the poverty problem. Programmes tended to emphasise direct supervision combined with extreme caution in the area of direct material provision.

In Britain, this first stage of prescriptive policy development was marked by such things as the transformation of the workhouse. What had been the deterrent workhouse became a range of differentiated 'poor law institutions' in this period, including children's homes, homes for the aged and separate wards for infectious patients. The poor law system continued to lean heavily on indoor relief (i.e. made institutionalisation in a workhouse a condition for receiving assistance), but simple

deterrence was being replaced by training or treatment based on an increasingly complex system of classifications strictly separating the 'respectable' from the 'depraved' (Crowther 1978:37-52).

The programmes in this period tended to emphasise assistance in the form of training, treatment, supervision and expert advice[63]. Mothers and children especially were placed under various forms of state supervision (clinics, health visiting, medical inspection in schools, physical training) as were those who cared for them (e.g. midwives, supervised under the Midwives Act of 1902). Those who couldn't care for themselves for a respectable reason (old age, youth, mental handicap) were put into poor law institutions with less stigma and a reduced emphasis on deterrence.

State assistance was seen as necessary, but at the same time it continued to be regarded as a dangerous threat through creating a cycle of dependency. Thus the Unemployed Workers Act (1905) emphasised public works rather than benefits for the unemployed. Thus both reports of the Poor Law Commission emphasised the need for state assistance to prevent people from falling into the abyss of impoverished dependency, but this was to be achieved primarily through detailed classification and supervision rather than cash benefits.

Britain, however, was further along the trajectory towards the welfare state (the second stage above) and new programmes introduced in this period began the trend towards direct (though

not yet universal) state provision. These included national frameworks for the provision of school meals (1906), medical treatment in schools (which developed rapidly out of medical inspection introduced in 1907), Old Age Pensions (1908) and National (health and unemployment) Insurance (1911).

These programmes could be accurately characterised by Doyal's (1979:166) description as "state sponsored self-help", in which contributions from recipients (as a class, not individually) would (to the maximum extent possible) defray the costs. The exception was Old Age Pensions, which operated on a non-contributory basis though with strict conditions for eligibility[64].

Despite these limits, these programmes represented a cautious breakthrough into direct state provision, though still a long way from universal programmes and primarily economic regulation. In the realm of public health, this meant that in Britain officials debated, developed and implemented programmes in which direct benefits were provided to those who could not afford them on their own, including: school meals, medical treatment and (a limited number of) creches or day care centres. It also meant that the arching of public health away from broad environmentalist and eugenic theories towards a more limited medical model centring on early treatment was beginning in Britain in this period. Finally, local programmes were generalised through the national state and (in many cases) made mandatory as direct provision expanded.

In Canada, this breakthrough to direct benefits was not yet underway. Programmes such as Old Age Pensions had influential advocates in Canada, such as the Trades and Labour Congress and the Social Service Council of Canada uniting churches, women's organisations, labour unions and other reformers (Guest 1980:32-6). Special committees of the federal parliament twice considered and rejected the provision of pensions in the period 1906-14, just as the Ontario Commission on Unemployment (1916) considered and rejected unemployment insurance (ibid 34-5,70-1).

In fact, the absence of direct material provision by the state in Canada had a long history. When the colony of Upper Canada (Ontario) adopted the framework of English civil law in 1792 the (Elizabethan) Poor Law was explicitly excluded. This represented an exception to the general trend among British colonies to adopt Poor Laws. While the precise basis for this rejection is not clear, the result was that relief was not systematised in Ontario which relied instead on private charities in combination with municipal relief governed by permissive legislation (Splane 1965:65-73).

Similarly, the Poor Law was not introduced in Lower Canada (Quebec) after the British conquest. There, relief tended to be operated through the Catholic church (for the francophone majority) and later through the Protestant churches as well (for the anglophone minority). By the period 1860-1920, it was only in Nova Scotia and New Brunswick, which were not at the centre of the industrial boom, that any systematic poor relief coordinated

at the provincial level based on the poor law system had developed (Guest 1980:12-14,210-211n.15).

The Poor Law in Britain was one of the crucial mechanisms through which the British state encountered social problems through the nineteenth century. The whole process of forming a working class in Britain, and the resistance to that process, had generated a rudimentary network of institutions through which obstacles for reproduction became problems for the state. This was the foundation on which the new programmes of this period were erected. In Canada, the absence of such a network of institutions meant that the state had neither the apparatus nor the conceptual framework(s) to problematise and act on social problems as industrialisation took off.

In short, Canada did not have the institutional legacy of previous crises in reproduction that the British state did by the turn of the century. In Britain the problem of dependence on Poor Law relief had generated much of the initial impetus to public health measures. In at least one Canadian example, this process was reversed as the Toronto public health apparatus came to serve as a coordinating centre in an effort to systematise municipal and private relief (Bator 1979b:45-8; Royce 1983:54-7).

This institutional legacy does not, in itself, explain the gap in systematic state material provision between Canada and Britain in this period. It was one of a number of contributing factors. The proper enumeration of these factors, and evaluation of their impact upon the development of state social services in

this period, lies beyond the parameters of this thesis. However, some of the most important considerations can be listed here.

One important difference was in the development of the working class movement in Canada. Though the tempo of class struggle accelerated in the period leading up to World War I, the impact in terms of mass working class organisation or the response of the state was not as great as that of the British 'labour unrest'. Only in 1919, the year of the general strike in Winnipeg and elsewhere, did the Canadian working class constitute enough of a problem to really concentrate state activity. Even then, the long downturn following the ultimate defeat of 1919 meant that mass working class organisation and the state response of regulated collective bargaining and welfare programmes would not be fully seen in Canada until during and after the Second World War[65].

Union militancy was not the only factor that made the condition of the working class a problem for the state. As discussed above, the heavy immigration into Canada in this period meant that the Canadian state (at all levels of government) could read social problems as the importation of seeds of degeneracy. The question of selecting immigrants so as to root out potential bearers of degeneracy often overshadowed and obscured the origins of social problems in the condition of Canadian cities. While immigration was also regarded as a cause of problems in Britain, at the level of state policy-making domestic conditions remained the primary concern.

Accompanying the immigrant question in Canada was the ideology and reality of frontierism[66]. The formation of an industrial working class was not the only object of Canadian social policy in this period. The settlement of the west and the development of agriculture there was also a major (perhaps the major) priority. Along with the reality of western settlement as an object of social policy went the new world frontierist ideology of self-reliance, self-improvement (relative to the old country, relative to parents) and mobility. In contrast, in Britain the only frontier was the empire and the primary object of social policy in this period was working class formation and maintenance.

Related to this was the whole issue of late development and learning the lessons of predecessors. The Canadian state in this period was attempting to avoid the pitfalls in the path already followed by the Europeans and (to some extent) Americans. Canadian policy-makers were optimistic that it was possible to learn from previous examples and prevent the problems of degeneracy from taking root by correcting slum situations without relief which created dependency, carefully screening newcomers, and avoiding excessive class confrontation. This led to a particular caution in the area of direct provision of material assistance, which was associated with the spread of pauperism and dependence elsewhere[67].

Finally, Canada and Britain were located at different points in this period of intensifying imperialist competition. As

discussed above, the development of an 'imperial race' was a policy priority in Canada and Britain, but at the core of the Empire this problem was more sharply conceived than at the dominion level. As Britain was struggling to remain a superpower in a period of intensifying international competition, Canada was just emerging as a nation. This was true not only at the level of state priorities and ideologies, but also at the level of the economy where Canadian capitalism was a minor player on a world scale.

Canada, then, had a social policy less oriented to direct provision than that of Britain as a result of a less developed state infrastructure to problematise social conditions, a less organised and combative working class, the conditions of frontierism, large scale immigration and a different location in the age of imperialism. This does not mean, however, that Canadian social policy was stagnant during this period. The changes were not as substantial as in Britain, but they were certainly important.

This period saw the development of a substantial middle class reform movement in Canada, bringing together the developing women's movement, religious groups, a variety of experts either employed by the state or oriented around state policy, and others interested in moral and physical improvement. This movement tended to centre around a cluster of issues seen as related: temperance, women's suffrage, the suppression of vice, housing and urban planning, mother and infant welfare and the training

and development of children. While the movement was far from uniform, in fact consisting of a vast array of separate organizations, there was a great deal of overlap in terms of personnel, ideology and campaigns[68]. This period also saw the beginning of the crystallization of the reformist wing of the labour movement in Canadian politics at least in part through its participation in this social reform movement[69].

One specifically North American feature of this reform movement was the ideology of conservationism which played an important role in it. In this period, there was a large push for the rational state planning of resource exploitation. Within the conservation movement, labour was seen as a national resource of tremendous value, to be conserved through state planning along with trees, water, soil and minerals. In Canada, public health was one of the major areas of interest in the federally-appointed Commission of Conservation which from 1909-21 acted as a think-tank on resource planning[70]. In many ways, conservationism represented the obverse of frontierism in North American state ideology.

In summary, then, this was a period of activism in social policy in Canada as in Britain. It saw the first dramatic steps towards the prescriptive regulation of working class reproduction. Yet, there was no breakthrough to direct state provision in Canada, nor was the degree of generalization of programmes (from local to higher levels of government, from permissive to mandatory legislation) as great.

This difference in the character of social policy was reflected in public health. Where in Britain public health officials found themselves responsible for substantial, national programmes of direct provision for school children (meals and treatment through clinics) by the end of this period, this was not true in Canada. Rather, the emphasis in Canada was almost exclusively on educating parents to feed, care for and seek treatment for their children. Toronto's Medical Officer of Health (MOH) argued, "...probably nine-tenths of the efficiency of all public health work is educational" (Hastings 1916b:1100).

The equivalent figure in Britain in this period, where public health involved a degree of direct provision, was probably seven-tenths. The emphasis was still on education, but the provision of key goods and services was to act in Newman's words, as "object lessons" (Newman in UK. Bd of Ed 1914:220).

Canadian public health programmes tended to remain at the level of local initiatives, with higher levels of government playing at most an enabling role. The federal government was responsible for the medical inspection of immigrants and for a degree of conceptual thinking and propaganda (e.g. through the Commission of Conservation, a body with a broad policy research mandate). The provincial governments generally passed permissive legislation and took responsibility for certain kinds of policy or laboratory research. It was at the municipal level that the greatest advances took place.

In Britain, local initiative had also been the primary area of development for public health policy until about the turn of the century. However, in this period certain important programmes were generalised and standardised through the country. Thus the uneveness between programmes in various Canadian cities was not as likely in Britain. Further, the introduction of national funding in Britain allowed for the extension of direct provision programmes beyond the limits of local rates.

Finally, British public health was further on the trajectory towards medicalisation and an emphasis on treatment that would leave it as a minor specialty by the time the NHS developed. This went along with the general shift in social policy from social to economic regulation of the unemployment problem. In Canada, this shift was not yet underway, and the medicalisation of public health would not really take off until the mid-1920's.

In the British social policy of this period the tendency towards the recasting of social problems into the economic problem of unemployment and the medical problem of illness was beginning to be evident. In Canada, this shift had not yet begun, and the totalising concept of physical, mental and moral health was essentially unchallenged at the forefront of social policy.

2.3 Public Health and State Theory

The previous section established the general relationship between public health and social policy in the period 1900-20. In this section, the theoretical basis for this relationship will be examined in more depth. This examination will take place at two levels. First, the section will look at the way public health policy-making was structured as an aspect of state social science, employing its basic methodological approaches and reflecting its ideological orientation. Secondly, this whole process of policy-making will be located in a broader theoretical conception of the state regulation of the social reproduction of the working class. In sum, this section will attempt to explain the basic direction of public health in terms of the non-neutrality of the capitalist state.

2.3.1 Public Health and State Policy Science

Public health developed practically, theoretically and methodologically as an aspect of early British social policy. It was a specific application of state policy science as developed in the 1830's-1840's. This state policy science can be understood as a sociology, employing particular research methods and theoretical tools to define, investigate and solve social problems[71].

The health of the British working class was constructed as problematic according to the particular priorities of the state as understood by policy science. Having defined public health as

a problem, the next step was empirical investigation to objectively determine the correct course of action. Early British state policy science had a highly empiricist orientation. State policy mobilized facts to make decisions within the general framework of political economy (Abrams 1968:10). The facts accumulated by the state through empirical investigation formed a centralized and privileged basis for policy decisions.

> The centralisation of knowledge requires facts - and the legitimisation of some facts, and the methods used to collect them, against other facts - to justify features and forms of policy (Corrigan and Sayer 1985:124).

This accumulation of facts was called statistics. In this early period, statistics referred in general terms to the empirical science of statecraft, rather than the specific numerical method.

> ...statistics in the early nineteenth century was more commonly defined by subject matter than by method. The statistician or statist was, according to that tradition, one interested in the objective study of the problems of the state (Eyler 1979:19).

Farr, a contemporary of Chadwick's and Britain's first Registrar-General defined statistics as 'the science of States', and argued:

> ...politics, like war, has to submit to the spirit of the age, and to call in the aid of science: for the art of government can only be practiced with success when it is grounded on a knowledge of the people governed, derived from exact observation (Farr cited in Eyler 1979:28).

This knowledge tended to take a particular form, "aggregated data about the circumstances and behaviour of individuals" (Abrams 1968:11). Statistics represented the quantification of

population, the enumeration of the people belonging to a particular state[72].

Perhaps the most important use of this early statistical method was in Royal Commissions. More than 100 Royal Commissions were established in the period 1832-49, and every major piece of social legislation from 1832-71 began with such an inquiry (Finer 1832:39)[73]. These Commissions represented the systematic marshalling of facts to answer specific policy questions. One of these Commissions, Chadwick's 'Report on the Sanitary Condition of the Labouring Population of Great Britain', was the key document of early public health in the English-speaking world.

Of course, these Royal Commissions were not so innocent of theory as they claimed. They tended to represent the aggregation of theoretically-informed observations and impressions according to the often implicit perspective of the primary researcher(s). Corrigan (1977:278) described Chadwick's 'open' method of inquiry as "...restricted as to questions, participation and perspective."

The primary sources of facts for these inquiries tended to be institutional administrators, state inspectors and a particular layer of middle class reformers. Abrams (1968:20) wrote of early British empirical investigations: "....their findings were inferences from the correlation of institutional statistics." The observations, opinions and impression of a particular layer of officials and allied thinkers represented the first level at which theory entered such Commissions[74].

This data, inflected with certain meaning at the source, was then re-interpreted by the Commission according to particular and often unstated theoretical premises. Chadwick, for example, did not tend to use empirical material as a systematic foundation for his major conclusions[75]. Rather, he used a set of unstated premises (about state, economy and society) to structure theoretically-informed observations (his own and those of others) to identify and justify a particular path of action. The brilliance of Chadwick did not lie in his empirical rigour, but rather in his ability to develop practical programmes through the application of a sophisticated (though often unstated) social analysis to concrete situations[76].

This method was not simply a product of the relative underdevelopment of empirical sociology in Chadwick's time. The application of a social analysis to concrete situations in order to obtain a guide to action remained central to early twentieth century public health. Despite their empiricist claims, much of the important work of public health officials lay in the area of social and political analysis. The President of the Society of MOHs in Britain argued that MOHs must "...show in short that we can be philosophical sociologists as well as professional sanitarians" (Pattin 1909:41).

P.H. Bryce, a leading figure in Canadian public health in this period, described the role of political interpretation in his work:

> I have during the past twenty years endeavoured not only to investigate conditions and judge of the broad results viewed

> from the scientific standpoint, but also the bearing of particular features of public health acts in so far as they have affected the vital and material interests of our communities (in Ont.PBH 1903:36).

The empiricist claims of public health officials were in many ways more expository than methodological. Privileging their perspectives and programmes as scientific necessities based on unassailable facts enhanced programmes of public health education. Clarke (1916:97), an important public and mental health official in Canada, wrote:

> While those who discussed the question of the feebleminded did so in general terms, little or no advance was made in the way of attracting public attention to the importance of the problem...only when disagreeable facts are thrust home with sufficient force do they realize the danger in their midst.

The pioneering clinic he headed would therefore conduct research, "...with the idea of accumulating facts with which to carry on a propaganda in regard to the desirability of attacking social problems of vital importance to the state." Facts, then, were to be accumulated as weapons in a propaganda war, not as tools for deeper knowledge[77].

This is not to deprecate the empirical work done by public health officials. Rather, it is to argue that public health in the period examined was structured more by its dynamic social analysis than by its marshalling of specific facts. Later, the fragmentation of public health within an increasingly medical framework would see a simultaneous sharpening in empirical rigour and narrowing of social vision.

It should not be surprising that empirical rigour in itself was not seen as a central goal of public health. State policy science tended to be oriented towards ends not means[78]. At the core of public health lay a commitment to theoretically-informed pragmatism. The major project of public health research from the outset was not the search for root causes but the identification of solutions to social problems lying within the bounds of possibility.

Pragmatic reasoning underlay Chadwick's seminal report. The whole focus on sewers, water supply and ventilation was based largely on expediency:

> The defects which are the most important, and which come most immediately within practical legislative and administrative control, are those chiefly external to the dwellings of the population, and principally arise from the neglect of drainage (Chadwick 1965:99, also pp.167, 217, 256, 423).

The whole inquiry aimed to identify, "...the chief removable circumstances affecting the health of the poorer classes of the population" (ibid:75). This concept of the 'removable evil' or 'controllable influence' persisted in public health (e.g. John Simon in Frazer 1950:90, Newsholme 1925:1). Removable in this context meant within the parameters of state action, 'within practical legislative and administrative control', or in Newsholme's (ibid:72-3, cited p.25 above) words "so far as this is or can be secured by the action of local or central authorities concerned with any part of government".

Public health activity was constrained by the capacity of the state apparatus (e.g. tax base, political parameters of

acceptable action) operating within a framework which took basic social relations (wage-labour, the family system, the nation state) as given. These limits were not static, but changed according to shifts in economic and political conditions. 'Removable evils' were those obstacles to health which could be dealt with through the state (at a particular moment) without compromising the functioning of the home, the workplace or the nation.

This is not to say that public health officials simply ignored everything that was not a 'removable evil' by the standard of the times. On the contrary, they frequently ran up against these limits. John Simon's statement on infant mortality is typical of their response upon encountering the limits of their actions.

> But the root of this evil is perhaps out of the reach of the law - certainly out of the reach of the remedies which I am competent to advise (cited in Lambert 1963:337).

At times, officials were more audacious and advised remedies far out of the realm of their competence. The MOH of Toronto, for example, ended an article with a rather radical-sounding call for full employment at a living wage:

> But in this democratic nation, it seems rather contradictory that 51 individual multi-millionaires hold one-third of the entire wealth of the nation, and 450 hold nearly nine-tenths of the total wealth...In the interest of the future destinies of our nation it should be possible for every man to receive a wage that would enable him and his children to be so housed, so fed and so clothed, as to develop the best and highest that is in him (Hastings 1917:90).

Nor was this exceptional. The President of the Society of MOHs in Britain called for the provision of basic subsistence

requirements to all (Pattin 1909:40-1). While officials were in a position to advocate some of these changes, they were certainly not able to deliver them. Hastings' legacy to Toronto was an innovative system of public health nursing, not a radical redistribution of wealth[79]. Newman (1909:161) argued that in school medical inspection, "...we must aim, not at the best, but at the best that is practicable" (emph. orig.). This was perhaps an accurate description of the broader orientation of public health.

Broader questions regarding the link between social conditions and health tended to be displaced within the framework of public health by those of removable obstacles. This meant specifically that the key questions of poverty and class tended to be displaced by partial issues seen as actionable within the limits of the capitalist state[80]. Broad correlations, especially between poverty and illness, tended to be displaced by narrower, more partial ones, between dirt and health, maternal behaviour and mortality, etc.

The relationship between poverty and disease was not necessarily denied by officials. Newsholme wrote: "It is unnecessary to labour the point that infant mortality is highest among the poorest and lowest among the well-to do." However, he explained that this difference was not due to poverty in itself. If it were, "...the death-rate in Ireland and still more so in Norway should be much higher than in England and Wales." In the

end, this broad correlation between poverty and illness is ascribed to other factors associated with poverty:

> The difference in the main is due to certain removable evils, which are commonly associated with poverty in this country, and from which the well-to-do in large measure escape (UK.LGB 1910b:55).

This tendency to displace poverty as an issue within public health led to contradictory experiences for officials on the ground. A Toronto visiting nurse in tuberculosis work expressed her frustration at battling daily against the obstacles posed by poverty:

> Speaking for myself, I must confess that the results of my work fall far below even what I might expect from such energy as I have expended... Poverty is perhaps the greatest drawback...(Neilson 1910:337).

She went on to show how little impact her advice could have in situations where poverty imposed very real limits on behaviour. She gave examples of men just out of the sanatorium returning immediately to work, and women, "who are working, or have worked themselves into their graves." The displacement of poverty in the public health framework left home visitors with no tools to deal with the most pressing problems in the households they tended (save referral to other social agencies), except for advice which could not be acted on due to material constraints.

This tendency towards displacement within public health also marked state policy science as a whole. The commitment to the possible, given the constraints limiting the capitalist state, was crucial in orienting state policy science. The consistent

use of the inspection method was one of the ways in which this commitment was manifested.

The cardinal feature of the inspection method was its relative nature, generalising from the best or most advanced example to others. Rather than attempting to enforce abstract and absolute standards, the central task of inspection was the identification of models as a basis for defining acceptable limits for others (Corrigan 1977:153-9). Inspection based on generalisation was from the outset a central enforcement method of public health. Chadwick (1965:407), for example, argued that permanent public health medical officers were necessary as single spot inspections by medical people without a grounding in the general situation were inadequate.

> A medical man who is restricted to the observation of only one establishment may be said to be excluded from an efficient knowledge even of that one.

Generalising from what has already been achieved in practice by the most advanced was one of the most effective ways of orienting to the possible. The models for public health were drawn not from the imagination, or even from a materialist reading of the potential, but from what operated concretely down the street or in the next town.

A retrospective look at the development of public health work in Ontario began with the statement:

> a brief study should be made of the progress which has taken place in the evolution of public health work, not only as a branch of state and municipal work, but as an exact science (Ont.PBH 1902:8).

Public health in this period was more a policy science than an exact one. This state policy science intersected with the sociology of reform of activist middle class voluntary organisations in this period. This sociology of reform saw two major obstacles to social improvement. On the one hand, the working class itself was seen as ignorant, amoral (at best) and highly limited in its capacity to help itself. On the other hand, the upper classes, which did have the capacity to help, were too greedy, self-centered and short-sighted. That left the enlightened members of the middle class in a privileged position to help.

This sociology of reform was clearly put by A. Shortt, a member of the executive of the National Committee of Women, in an article in Public Health Journal. Shortt (1912:311) described the working class as:

> ...that lower strata, that great weltering mass of people whose lives are merely enlarged expressions of their two primary biological instincts of reproduction and self-preservation...and whose outlook is bounded by their personal experience. It is from this group that our social problems mainly spring, as well as dangers that threaten our race and country.

In contrast, the idle rich were characterised as:

> ...the more or less selfish class, who are comfortable in their environment and occupied with their own ambitions and pleasures...who have opportunity, intellect, means, but who, ostrich-like, keep their heads in the sand and refuse to see approaching evil or danger (ibid).

Finally, there were the enlightened members of the middle class:

> Between these two groups is the third great group of men and

> women who are the saviours of the others...[who] contend with both groups, trying to educate both, trying to hold back the crowding dangers of ignorance, feeble-mindedness and vice and all the insidious evils that push and crowd us from below, striving with both hands to hold back one group while calling ceaselessly to the other that old Macedonian cry, "Come over and help us."

The image that Shortt presented of the middle class physically interjecting itself between the other two classes accurately captured the impulse of a range of reform movements, including: settlement houses, visiting social workers, recreation programmes (including the YMCA) and rescue missions. This activity grew out of the feeling that the middle class had a privileged perspective on the problems of capitalist society and a concomitant responsibility to do something. It was a particular example of a general tendency in middle class politics under capitalism noted by Marx (1969:424):

> ...one must not form the narrow-minded notion that the petty bourgeoisie, on principle, wishes to enforce an egoistic class interest. Rather, it believes that the special conditions of its own emancipation are the general conditions within the frame of which alone modern society can be saved and the class struggle avoided.

These reformers saw themselves as representatives of a universal class, embodying the good of the whole community. By the turn of the century, however, these reformers were increasingly coming to see state action as the crucial complement to their own activity. Not only did the state (at least potentially) command greater access to resources than these reformers did, but it also embodied the good of the community to a greater extent. Reform movements were increasingly orienting themselves to the state as the vehicle to socially improve the

working class while curbing the worst excesses of the capitalists.

Public health was high on the agenda of these state-oriented reform movements. Many voluntary service programmes were taken over by the state, though philanthropy continued in its traditional role of direct service provision in certain sectors. Reform movements increasingly played an advocacy role, calling on the state to implement a programme of broad-ranging reforms.

In the area of public health, this broad programme included the integration of medicine into the state and the development of cradle to grave (actually womb to grave) regulation to serve the goals of national health[61]. A Public Health Journal Editorial[62] (1912:87) criticized sections of the British medical profession for opposing the National Insurance Act of 1911:

> Thoughtful physicians now recognize the ultimate meaning of the growth of public health sentiment and understand that certain of their number must suffer in the natural evolution of medicine from the research quelling commercialism of modern practice to a more dignified place in state ministry.

This combination of medicine with the state would provide the basis for the scientific regulation of the population. A vision of this regulation was presented in a Public Health Journal Editorial (1912:198), which described "the promised land of medicine" that:

> ...assumes control at birth both of mother and child, the daily surroundings of both ... presumes to dictate the age at which the child is physically and mentally ready for school, the hours and methods of study, the sanitation of the school room ... attempts to determine the age at which the child shall begin to assist the state by leaving school and entering upon its life work...and theoretically adjudicates upon the conditions under which men and their families shall live and work in our crowded cities...

This vision of augmented state regulation was remarkably similar to Fabianism[83]. In fact, some public health officials actually described this aim as 'socialism'[84]. It was perhaps more aptly described by Hastings (1919:103) as, "...socialism purged of its anarchy and other objectionable features".

This regulatory regime could be characterized in the words of Wesbrook (1912:491) as "compulsory betterment." It required the subordination of the individual to 'society' as 'represented' by the state (ibid, also Struthers 1913:89, Reid 1913b:287)[85]. This compulsory betterment was to produce a more efficient and productive working class as the basis for national prosperity.

Public health was one of the foremost examples of state policy science until the 1920's. In this period, state policy science intersected with the reform sociology of the middle class philanthropic movement. As a policy-oriented social science, the focus of public health was less on exactness than on pragmatism, less on narrow medical concerns than broad (if implicit) social theory. Having located public health within state policy science, it is now time to look more broadly at the orientation of the state to questions of social reproduction.

2.3.2 The State, Social Reproduction and Public Health

Public health developed as an instrument of social policy, one of a range of methods employed in the state regulation of the social reproduction of the working class. This regulation had particular dynamics, it took place within definite material and ideological limits. This section will look at these dynamics generally in order to draw some specific conclusions relevant to the examination of public health.

Marx (1977:711) wrote, "... every social process of production is at the same time a process of reproduction." It is characteristic of any social production process that it consumes the elements vital to it. These elements must be incessantly renewed if the process is to continue. Supplies of materials must be replenished. Machinery and tools must be maintained and sometimes replaced. Most importantly, the human beings who labour in the process must be fed, rested, refreshed and (as they are mortal as well as subject to injury or disease) replaced. "This incessant reproduction, this perpetuation of the worker, is the absolutely necessary condition for capitalist production" (Marx 1977:716).

Yet this 'absolutely necessary condition' is not met within the cycle of reproduction of capital. Within that cycle, what takes place is "... the consumption of labour-power but not its production and the production of articles of consumption but not their consumption" (Lebowitz 1982:44). A second production process is required, then, "...one in which labour-power is

produced in the course of consuming articles of consumption" (ibid.).

The working class reproduces itself through a second production process outside of the sphere of capitalist commodity production. This process of self-reproduction requires access to consumption goods (food, clothing, housing, etc.) which can be obtained only through participation in wage-labour. Thus the reproduction of the working class depends on capitalist production (as the source of the wage and consumption articles) just as capital depends on a labour supply reproduced external to it (ibid:48).

Self-reproduction through the consumption of goods acquired on the basis of the wage requires a domestic labour process, rather different in character than wage-labour in commodity production proper. Workers perform wage-labour in the workplace, under the direct supervision of capitalists, in order to get a wage as a means to the necessities of life. In contrast, domestic labour is performed (primarily) in the private household, without direct supervision, and for its own sake[86]. The burden of domestic labour has fallen primarily on the shoulders of women, whether or not they were also engaged in wage labour[87].

The character of domestic labour as private, unsupervised and done for its own sake led Marx (1977:718) to write:

> The maintenance and reproduction of the working class remains a necessary condition for the reproduction of capital. But the capitalist may safely leave this to the worker's drives for self-preservation and propagation.

It is not true, however, that working class self-reproduction is unproblematic from the point of view of the capitalist. At one level, the individual employer generally does leave his or her own workers to reproduce themselves[88]. Yet at another level, the reproduction of the working class is problematic for three reasons.

First, the end result of the process of working class self-reproduction is not labour-power itself, but potential wage-labourers who are bearers of labour-power. It is therefore a constant problem for capitalists to ensure that this potential labour power is actualised, sold by its bearers under specific conditions. It is necessary but not sufficient that workers do not own the means of production and must therefore sell their labour-power to obtain means of subsistence. Various regulation processes are required on top of this essential compulsion to realise the potential labour-power borne by workers (Aumeeruddy et al 1978:48-9).

Secondly, as workers sell labour-power for their own ends (to obtain commodities for self-reproduction in the family) the terms of sale are an area of struggle and negotiation. The buyer and seller of labour-power have very different and contradictory aims. Workers seek the wages, time and capacity to reproduce themselves just as capitalists require certain levels of exploitation and various quantities and qualities of labour-power. The systematisation and channelling of these struggles so as to maximise the establishment of provisional settlements and

minimise the occasions for generalisation becomes a major problem for capital (see Lebowitz 1982:47-9, Aumeeruddy et al 1978:45-6).

Finally, capitalism creates a working class that is 'free' (owner of his or her body, not tied to the land or a master, and free of the possession of means of production) and therefore mobile. At the same time, the dynamics of the system are such that the reproduction of the working class is not simply a matter of steady supply (e.g. through generational replacement), but one where labour shortage succeeds labour surplus in ongoing, irregular cycles. The system therefore requires the production of a surplus population of workers which Marx (1977:784-94) called the 'industrial reserve army'. Further, labour mobility becomes a particularly potent weapon for employers in the class struggle as new sources of cheaper labour (off the land, out of the country, from the home) can be brought in to undercut the cost of wages and divide the working class (Lebowitz 1982:49, Aumeeruddy et al 1978:55). Thus the management of labour mobility becomes a problem from the point of view of capital.

Working class reproduction, then, is problematic from the point of view of capital for the three reasons just cited. Capitalists cannot simply leave it to the worker's own drives. Yet, the individual capitalist is not in a strong position to respond to these problems. First, the individual capitalist in competition with others is generally in a poor position to unilaterally raise wages, reduce the work week and reduce the

physical and mental toll of the working day, let alone provide necessary food, housing and so on.

> Capital therefore takes no account of the health and the length of life of the worker unless society forces it to do so...it is evident that this does not depend on the will, either good or bad, of the individual capitalist. Under free competition, the immanent laws of capitalist production confront the individual capitalist as a coercive force external to him (Marx 1977:381).

Secondly, the reproduction of the worker takes place outside of the sphere of commodity production. Aumeeruddy et al (1978:48) wrote: "...the capitalists cannot control the reproduction of the bearer of labour-power and of the conditions of wage-exchange from within the field of value." The private labour process through which workers consume commodities and reproduce themselves is beyond the realm of control of the capitalist. The direct intervention of capitalists as employers into this realm threatens the 'freedom' of labour and the limited nature of the labour contract (see Marx 1977:271).

It is therefore the capitalist state rather than individual capitalists which responds through regulation to problems in the reproduction of the working class. This is not to say that this state regulation developed inevitably out of the requirements for capital accumulation. Rather, it developed historically as a series of responses to obstacles posed through the class struggle[89].

Capitalism does not necessarily require that the conditions exist for healthy working class reproduction. Historically (and up to the present day in some third world situations) workers

received neither an adequate wage to meet basic consumption needs nor the time required for the private domestic labour process. The working class family tended to be loosely structured. The working class was reproduced primarily through migration, while those already employed were used up quickly in a process of production without adequate means of reproduction.

This system tended to give way in the developed capitalist countries as the working class struggled for the wages and time to stay alive and raise children, while reformers fought to establish the working class family as a basis for social and political stability. This was an historical development, the product of particular conditions, struggles and decisions. There is an historical process through which problems in the reproduction of the working class (from the point of view of capital) become obstacles to the reproduction of society.

This process has particular characteristics reflecting the nature of the state in capitalist society. The capitalist state is an historical product of capitalist social relations which is charged with the reproduction of society within certain national boundaries (i.e. the reproduction of the nation). The state can only act to reproduce the nation through creating the conditions for the reproduction of capitalism. The material prosperity of the nation depends on the production of use-values which can only occur within capitalist society through the process of the production and accumulation of surplus value (Clarke 1983:123). The state is driven through capitalist economic and military

competition on a world scale to attempt to create the conditions for capital accumulation on a national scale (as the basis for taxation, employment, arms production, etc.)[90]. The state can only exceed the limits of capitalist reproduction at the cost of provoking social breakdown, a crisis marked by class struggle and problems in material production and international relations (ibid.).

The state is not an autonomous body mediating between the needs of capital and the demands of labour. The relationship between the state and capitalist social relations is not an external one marked by the coming together of separate forces, but an internal one:

> State forms are related to the social relations and conditions of specific modes of production in their historical development. State forms are not related contingently and accidentally, nor are they externally related...but, rather, internally (Corrigan, Ramsey and Sayer 1980:5).

Yet the state appears neutral in the realm of social policy for two reasons. First, both capitalists and workers have interests in the reproduction of the working class; the former as the source of labour-power, the latter as self-preservation and self-realisation. These interests are contradictory and opposed, reconciled only through class struggle. Yet this coincidence of interests can give social policy reforms the appearance of being in the interests of all[91].

At a more general level, social policy appears neutral on the basis of the separation of the state from civil society.

This separation is a specific characteristic of capitalist relations. Sayer (1985:231) described this separation as:

> ...the emergence of a distinct 'civil society' - the arena of individual, private, particular interests - and the 'political' state - the locus of general, public, universal concerns.

The state, then, appears as the only embodiment of the community, the general interest or the nation as a whole as opposed to particular and antagonistic interests. Marx (1976:86-7) referred to the state as one of the "substitutes for community" which developed in class society. Such substitutes were only illusory communities as they formalised a society based on class domination.

> The illusory community in which individuals have up till now combined always took on an independent existence in relation to them, and since it was the combination of one class over against another, it was at the same time for the oppressed class not only a completely illusory community, but a new fetter as well (ibid.).

The state as the embodiment of the illusory community appears to act neutrally to assert the interests of all in the preservation of the prosperous and peaceful nation, as against the competing interests of other nations abroad, or of particularistic forces (whether capitalists or workers) at home. The complementary relationship between the state and civil society leaves the state as the only representation of the general interest. Yet at the same time the separation of the state from civil society limits the capitalist state, as "...[t]he state merely gives form to social relations whose substance is determined in civil society" (Clarke 1988). Thus,

the state only represents the general interest within the confines of relations of class domination existing in civil society[92].

To sum up, the working class reproduces itself through a combination of wage and domestic labour. These two labour processes are very different in character. The private, unsupervised domestic labour process requires specific forms of regulation accomplished through the capitalist state. The state appears to engage in such regulation in the interests of all, and yet is confined to acting within the limits of capitalist relations.

Public health emerged as one aspect of social policy, the state regulation of the reproduction of the working class. The content and orientation of public health was determined by the nature of this state regulation. Both the limits of state activity and the specific character of the domestic labour process were crucial to the shape and direction of public health programmes.

At the most general level, 'national health' provides a useful example of the 'illusory community' formalised in the capitalist state separated from civil society. Public health aimed to improve the health of the community in the general interest. In practice, this meant eliminating diseases as barriers to wage-labour or positively augmenting the performance of wage or domestic labour. Poverty was problematised by public health as the result and not the cause of illness. The sexual

division of labour and racial or national divisions were encountered as unchangeable conditions of existence. The essential relations in civil society were limits on public health as state activity.

At a more specific level, public health programmes were shaped by contradictions inherent in the state regulation of working class reproduction in capitalist society. These contradictions will be outlined here and developed through the thesis.

The first of these was what Vogel (1983:154) identified as the contradiction between wage and domestic labour. Capital needs a sufficiently healthy, able and willing working class and yet this requires limits on the working day, adequate wages, etc. As Clarke (1983:125) wrote, "The need to force down the value of labour-power contradicts the need to reproduce labour-power..." It is true at one level that, "[a]ll the capitalist cares for is to reduce the worker's individual consumption to a minimum..." Marx (1977:718). Yet the impulse maximise the extraction of surplus value by restricting consumption is contradicted by the need to perpetuate the worker.

This contradiction touched public health most directly around the question of wage-labour for women. Public health officials sought to restrict paid employment for women (especially mothers) in order to improve their efficacy as domestic labourers. Yet this contradicted both the need of capital for particular quantities of appropriate wage-labour and

women's own need to participate in wage-labour to have access to resources. This contradiction could not be resolved at the level of public health, nor ultimately can it be resolved at all except through the perpetuation of class struggle.

The second contradiction concerns the regulation of private labour performed without supervision in the atomised situation of private households without at the same time socialising domestic labour. Public health officials were torn between the fear of undercutting family responsibility and independence (i.e. dependence on the wage) and the need to establish a certain level of standardised service as protection against the inevitable unevenness in the functioning of the family system. At times, this was resolved in favour of the partial socialisation of aspects of domestic labour (e.g. through school meals in Britain) as the only way to get the job done. More often it was resolved through an emphasis on tact and discretion in home visiting, on the education of the home-maker and the enhancement of self-discipline in domestic labour reinforced through spot inspections.

This contradiction between the privatisation and socialisation of domestic labour may account in part for the fact that state activity in this area at times took a philanthropic form. Mort (1985:210) argued that in the area of the regulation of sexuality in Britain in this period, "The state was a relatively subordinate and passive partner in the dialogue with purists and feminists." In public health generally, the state

was extremely active in policy-making, standardization and inspection, implementation and the stimulation of voluntary activity. It might be argued that state activity took a philanthropic form in specific situations where the fear of the over-socialization of private domestic labour was sharpest[93].

The examination of the way public health negotiated the contradictions discussed here will be a major focus of the next two chapters. More generally, the rest of the thesis will develop the argument that the shape and direction of public health reflected the specific character and limits of the state regulation of working class reproduction under capitalism.

CHAPTER 3
PUBLIC HEALTH AND THE NATION-STATE

3.1 Public Health and Nation Building

A. Nation and Class

Early twentieth century public health identified the well-being of the nation with the health of the producing population, particularly the working class. The prosperity, social harmony and competitive position of the nation depended on a working class well enough for work or war. A healthy (competitive, prosperous and harmonious) nation was in turn seen as the basis for the well-being of its people.

In the early years of the public health movement in Britain, the orientation to the health of the working class was explicit[1]. Gradually, the stated goals of public health became more universalistic; 'the sanitary condition of the labouring classes' was superseded by 'the health of the nation'. Implicit, however, in the broader conception of 'the nation's health' or 'the health of the people' was a specific focus on fostering a healthy, disciplined and morally sound working class. The journal Conservation of Life (1914)[2] contained the following statement on the inside cover of its first issue:

> Conservation of Life is the newer and broader Public Health...It seeks to minimize and prevent as far as possible disease, disability and waste in human life by the betterment of man's environment and occupation, assuring to all classes of the community those amenities which in their widest sense will produce the highest attainable degree of human efficiency. It is the centre around which gather and by which all our national resources are vitalized and without which there can be no truly national vitality.

The aim was to achieve human efficiency as the basis for production, the vitalisation of natural resources[3]. This was to be accomplished through ensuring that 'all classes of the population' (not just the well-off bourgeois classes) had access to the required amenities. The working class was to be treated as the nation's most valuable resource, to be conserved through state regulation just as natural resources. This was exemplified by the mandate of the Commission of Conservation (1910:8,12), a Canadian government advisory body which was guided by the principles that "...those resources which are necessaries of life should be regarded as public utilities..." and that the "... physical strength of the people is the resource from which all others derive value."

The improvement of working class health would serve the nation in two related ways. Internally, it was aimed largely at promoting social harmony and stability through improving the material and moral conditions of workers while curbing some of the worst excesses of capitalists. Internationally, it would improve the competitive position of the nation (and Empire) in the world economy. A stable, prosperous and competitive nation would serve the interests of all.

Public health officials were keenly aware that national health involved a dimension of competitive advantage. An editorial in the Public Health Journal (1913:374) stated that the members of the Canadian Public Health Association, "...are interested in seeing that Canada shall possess a people stronger

in mind and body than those of any nation under the sun." The need for this competitive orientation was most clearly put by Hodgetts (1912a:346) when he wrote that Canada must fulfill its Imperial duty by:

> ... the providing of men and women physically fit to enable us to hold our own in that chain of nations, so that, in the commercial struggle, which is not likely to become less strenuous as the years pass by, this Empire shall ever hold its own and fulfill the destiny for which it was intended.

Not surprisingly, this competitive orientation was sharpened during World War 1. The journal Conservation of Life (1915:173) asked: "Who can measure the enormous debt which the British army to-day owes to the public health legislation of the past 40 years?" Hastings (1917:49) wrote:

> Every nation, in time of war especially, expects every man to do his duty, but whether or not they will be in a physical condition to do their duty depends on whether or not that nation has done its duty by them in early childhood.

The orientation of public health in this period, then, was to improve the health of the working class in order to augment the productivity and military effectiveness of the nation. This orientation was summarised in a statement of the aims of public health by the President of the Royal Institute of Public Health in Britain:

> Sanitary science, about which so much has been said during the past few days, has for its aim the prevention of disease, the preservation of health and the prolongation of life - in other words, the maintenance of the whole of the people in a state of the highest efficiency for the labours of peace or the struggles of war (Smith 1902:525).

Public health in this period had a specific class content, even if this was couched in the universalistic language of 'the

whole of the people'. It was the working class, those who laboured in peace and struggled in wars, which was to be maintained at the level of peak efficiency. This was to be done by the state in the interest of the nation as a whole rather than in any particular class interest.

> But disease has also a relation to the State. Labour and capital may be said to be the two pillars upon which it rests; disease paralyzes labour and wastes capital. (ibid:131)

The paralysis of labour and the waste of capital weakened the nation and threatened the well-being of its population. This was to be prevented in the interest of all. Toronto's MOH summarised this preventive project when he wrote, "...departments of health must realize the fact that they are nation builders" (Hastings 1921:713).

B. Nation and Race

In the period under study, this project of nation-building was commonly conceived in terms of theories of race degeneration, discussed above. The use of the term 'race' was rather confusing in the context of this nation-building project. After all, nations and races did not share the same boundaries. The term 'race', as it was used in the public health literature, had three dimensions: political, cultural and genetic. These overlapped, and were often used in a rather ambiguous way.

The political dimension of race essentially referred to the national population, the people belonging to a particular state. Bailey (1912:439), for example, wrote: "The conservation of the

Canadian race is vastly more important than that of the Natural Resources, as the real wealth of the nation is its people." In this case, the primary consideration was the general level of productivity of the nation's people rather than the cultural traditions or the genetic material. The grounds for classification were political, the people belonging to a particular state.

The cultural dimension of race involved the whole bundle of language, religion, traditions and moral standards. Importantly, these could be learned, so that a process of cultural assimilation was possible. When Clarke (1919:441), for example, complained that immigrants were being brought so quickly that "we cannot Canadianize them", integration was evidently a possibility. In the public health literature there was a tendency to take for granted the existence of a 'national' race in this cultural sense.

It was assumed in Canada that the national culture was Anglo-Saxon (e.g. Bryce 1915:208), despite the bilingual character of the country and the diversity of its population base. Explicit references to francophone culture were extremely rare (e.g. Desloges 1919:5). In Britain, the conception of national culture in this sense reflected the perception that the heart of the Empire was also the cultural capital of the English-speaking world.

The genetic dimension of race involved what was presumed to be an immutable core of shared characteristics (physical and

mental) that was biologically given. This conception of racial characteristics, which generally included a presumption of superior and inferior races, was influential in the eugenics movement as well as more broadly at the time (Ludmerer 1972:21-3). Stapleford's (1918:289) statement, "The instinct for liberty is strong in the Anglo-Saxon blood..." is an example of this dimension of race.

In the retrospective examination of early twentieth century literature on the race question, it is generally difficult to clearly differentiate between these three dimensions of race. That is quite simply because these dimensions of race were generally considered to imply each other (i.e. to fit together as a single package such as 'the Anglo-Saxon Race'). In practice, however, these neat packages tended to come apart. People who were included in the race conceived politically (i.e. citizens of the nation) did not necessarily belong to the cultural or biological groups that officials saw as dominant. Similarly, people who were part of the dominant cultural or biological groups might appear on the border as undesirable immigrants (trying to join the race in the political sense).

In general, the environmentalist leanings of public health officials impelled them towards a sense of race which was cultural transmissible rather than biologically given. In this sense, they saw their task as the assimilation of all members of the race in the political sense to the dominant cultural group. At the same time, there was a population that was not assimilable

(for biological, personal or cultural reasons). The composition of this unassimilable population was debated, but the need to exclude them from the nation was not.

Theories of race degeneration played an important role in the public health policy-making process in this period. The project of nation-building was most often understood in these terms. Public health sought to deal with the threat of race degeneration through increasing the state regulation of the social reproduction of the working class. This meant both the regulation of family self-reproduction and of reproduction through immigration. The former will be addressed in chapter 4 of the thesis, and the latter below.

3.2 The Threat of Degeneration in Canada and Britain 1900-20

In the early twentieth century, public health was one of the most important forms in which the Canadian and British states regulated working class reproduction in response to the perceived threat of race degeneration. Every capitalist nation reproduces its working class through some combination of internal self-reproduction (i.e. existing workers maintaining themselves and raising the next generation through the family system) and external reproduction (i.e bringing in workers reproduced elsewhere, in rural areas or other nations). Public health regulation spanned both of these forms of reproduction, linking them together at the level of theory as a project of nation-building through combatting the degeneration of the race.

The conception of this project at the most general level was very similar in Canada and Britain. Theories of race degeneration provided the basic conceptual orientation to the problem of national health in both countries. The modes of intervention to solve social problems in both were derived from the theory and practice of the new hygiene.

At the same time, there were specific differences in the understanding of the public health project of nation-building in the two countries in this period. At one level, these derived from variations in social policy linked to each country's history of class struggle and level of economic development, as discussed above. At another level, these related to particular issues

deriving from the location of each nation in the context of the world system.

The importance in early public health of questions regarding the health of the nation in a world system of nations is not immediately obvious. Indeed, historians often link the introduction of public health measures specifically to conditions within England's industrial cities, with little or no reference to the world context[4].

From the outset, however, the national question was at least implicit in the development of public health. Capitalism generates contradictory tendencies, on the one hand towards the development of a world market (for labour as well as ideas and things), on the other towards the development of the nation-state extending deeper and deeper into all aspects of life within the country's borders[5]. This contradiction was central to the development of public health.

At the most obvious level, the intensification of the world market accelerated the transportation of goods and people, creating the basis for the rapid spread of epidemics nationally and internationally. One of the earliest forms of public health activity in Britain and Canada was quarantine, the isolation of infected persons (and at times goods) by preventing entry to a country until cured.

At another level, the national question was posed for public health through the process of proletarianisation. The increased mobility of labour on a national and international scale was a

crucial component of this process. The formation of a working class in England involved Irish immigration from early on. Links between the Irish and poor health were frequently drawn in early public health. The obverse of this was the enforced emigration of troublesome elements, whether pauperised or criminalised.

The national question, then, was implicit in early public health. It was the age of imperialism which placed it at the centre of public health theory and practice. The intensified economic and military competition between nations led to new initiatives in state activity aimed at forming a productive and militarily capable population. In Canada in this period, the national question in public health focussed on the formation of a national working class in large measure through massive immigration. In Britain, it focussed largely on the poor condition of the existing working class resulting from slum conditions, particularly pressing at the centre of empire.

Thus, degeneration in Canada was seen largely as an external problem imported by immigrants. In Britain, it was seen primarily as the product of slum conditions over generations. Neither slums in Canada nor immigration in Britain were excluded as factors in degeneration, but these were seen as relatively less important.

3.2.1 Britain: The Threat at the Heart of the Empire

In early twentieth century Britain, race degeneration was seen as a product of urban, industrial conditions which threatened the well-being of the Empire. The response to this threat largely took the form of social reform to regenerate the working class family as a solution to the slum problem. This response also included immigration controls and attempts to promote emigration. This section will examine the connection between the question of imperialism and public health in Britain and attempts to delimit a national population.

A. Imperialism

The issue of imperialism figured prominently in British public health and social policy in this period[6]. The intensification of economic and military competition between imperialist powers created a climate in which the efficient management of national resources was seen as providing a crucial edge. The Boer war had provided a startling reminder of how real was the threat to the condition of the Empire. This situation reinforced earlier concerns about the state of national fitness. The high rejection rate among potential military recruits, reported for example in a famous article by General Maurice, was seen as an important indicator of this lag.

> Good physique is essential to the greatness of a nation, and enquiries such as those made by Mr. Rowntree at York, and the article by General Maurice published in this month's 'Contemporary Review' cause us great searchings of heart as to whether the physique of the English people is being maintained at the high standard necessary to our future national welfare (Sherrington 1903:27).

The anxiety aroused among policy-makers by the Boer war elevated the traditional concerns of public health to a new level of topicality and urgency.

> There was never a time when the physical well-being of the nation was more in the people's minds than the present...We are still digesting the lessons of the South African war (Legge 1904:947).

The traditional concerns of public health, sharpened by an augmented conception of national well-being, moved to the centre of social policy. The population was seen as the most important of the national resources required for competition.

> The prosperity of a nation is maintained in the physical and mental development of its producers, and this result cannot be evolved by calling into existence an army of effete and rickety labourers, victims of early starvation and tubercule (Foard 1903:848).

Public health was one of the most important policy areas in the management of human resources. Sidney Webb told the Annual Dinner of the Society of MOHs that:

> He could not help thinking that the MOHs were doing already more than any other public officers to regenerate England- to make England even a more productive nation than it would otherwise be (Webb 1909:66).

Public health officials clearly saw themselves in this period as crucial supervisors of the reproduction in Britain of a race fit to compete. Imperialist competition was a spur to

public health activity in many areas. Health visiting, for example, was justified in imperialist terms:

> The human element must always remain the chief factor in power, and therefore I plead for a conservation of our national force, which at the present time can be best maintained and increased by the ministration of the health visitor in the country as well as in the town (Hill 1906:371).

Child welfare programmes were explained in similar terms: "True imperialism begins in the nursery, and the race in the future is to the nation with the best education of both body and mind" (Collins 1902:601). In short, the fittest race would emerge victorious from the race between nations. This was a race which the British had been winning. The difficulties in gaining victory in the Boer war indicated that this lead was being squandered due to lack of attention to the health of the people:

> It is somewhat strange that the very nation which, beyond all, is called upon to bear 'the white man's burden' - the Empire which holds dominion over palm and pine, the race which colonizes as the direct heir of the old Romans- should show itself so little appreciative of the necessity, the duty, and the honour of so forming the inheritors of her greatness that her schools are less efficient than those of any other nation (Scharlieb 1905:30).

Some public health stressed the immediately military side of imperialist competition. These saw preparation for war as the way to develop physical fitness and military capacity in the population.

> The health of a nation is its most valuable asset, and I should like to see every Manxman, Englishman, Irishman and Scotchman between the ages of 20 and 60, able to handle a rifle and bayonet, and if needs be take part in the defence of his country...I would encourage the military spirit from early youth upwards, as the best means of developing the physique, and the moral and physical grit of the nation (Barr 1907:515).

These officials tended to see the issues of national physique and military preparation as integrally related to the extent of being inseparable.

> Up to the present time, and apparently for many years yet to come, the two questions of physical culture and of national defence will be indissolubly interwoven - in fact, only when war has been entirely abolished will it be possible to regard them separately (ibid:75).

Others saw national health and military preparation as distinct issues.

> I trust I may not be misunderstood or relegated to the ranks of the so-called Pro-Boers if I state fearlessly that home defence by the practice of sanitary reforms is quite as important as that of military warfare...(Farquharson 1902:166).

Farquharson advocated imperialism through sanitary reform, stressing the role of women in achieving conquest through elevation rather than male might.

> ...what could be more calculated to increase our prestige and influence in India and other countries under British rule than sanitary measures furthered by the tact of British women?...Far more beneficial in the interests of international 'peace with honour' would be the practice of sanitary reform measures be than the force of the sword consequent upon the failures of male diplomacy...(ibid:170).

Military preparation could be seen as operating at cross-purposes with national health.

> To gain this end [an Imperial Race], let us look to the extension of education, to the spread of temperance, to the improved housing of the poor, and so raise the physique and morale of the nation, rather than squander on warlike armaments millions which could be more profitably employed (Andrews 1904:83).

Some of these arguments were certainly tinged with anti-militarism. The major point they had to make was, however, a practical one. Military training, especially in the schools, was

simply not the most effective way of developing a healthy class of men and women capable of working, fighting wars or making homes. Newman (in UK.Bd of Ed 1909:181-3) pointed out that military training started too late in life, reached only the most fit, and did not address the health needs of girls and women.

The question of national fitness went beyond the selection of proper exercise routines for schools.

> The problem of the improvement of the physique of the people lies deeper than the school. Decent homes and healthy surroundings, fresh air and sufficient food, are indispensable, if the race is not to deteriorate (Kekewich 1904:463).

The failure to address this question of national health would cost dearly both in terms of direct state expenditure on the unhealthy and decreased productivity.

> The aftermath of our neglect is the crowding of our hospitals and infirmaries, and the enormous consequent increase of expense to the nation... We are losers also in consequence of the resulting lack of stamina and the limitations of strength in our industrial and commercial workers, which decreases the productiveness of our industries (ibid:470).

There was a sense that Britain was losing her competitive position due to the failure to address questions of national health. Improvements in conditions in other nations were noted. "Now the foreigner is not only improving his education, but also his diet" (Collins 1902:601).

Perhaps the most sophisticated explanation of this competitive failure was in the Interdepartmental Committee on Physical Deterioration (ICPD).

> It must be remembered, in defence of our laxity in this respect, that the industrial development of Germany took place fifty years later than ours, when sanitary science with its multiform applications to the actual conditions of urban existence had come to be much better understood, and that we do not start de novo, but have in a large measure to undo the consequences of previous neglect (UK.ICPD 1904:19).

This question of competition through national health intensified as imperialism took a directly military turn during World War 1.

> The reasons for combatting, by every possible means, diseases which in normal times operate with disastrous effects upon the birth-rate and upon working efficiency are, therefore, far more urgent than ever before (UK.RCVD 1916:66).

One feature of intensified imperialism was the spread of colonial conquest. This led to the development of colonial public health programmes, such as the Colonial Medical Service and the India Medical Service. The late 1890's and early 1900's saw the development of Schools of Tropical Medicine in London and Liverpool[7]. Here the ideas of national or racial types featured prominently. The British Health Officer in Shanghai described the cleansing of Chinese dwellings.

> Many houses thus disinfected, visited three or four months afterwards, were still found in a clean and healthy condition, but the greater number had relapsed into their former condition of oriental squalor (Stanley 1908:103).

Public health played a leading role in the definition of new problems for social policy in response to intensified imperialist competition. This was a period in which the issue of imperialism was an immediate consideration in the reform of British social policy. Yet the leading role of public health in this social policy reform was short-lived. Public health helped define new

social problems which were beyond its capacity to solve. The regeneration of the family through social work methods and the medical selection of immigrants would give way to broader welfare measures linked to specifically political and economic immigration controls. Further, the kind of broad theorising which marked the analysis of public health and imperialism in this period would tend to fall out of favour with the development of more specialised and fragmented social policy programmes oriented to specifically defined problem areas.

B. Emigration

Forced emigration had a long history in Britain. In the nineteenth century, particularly its later years, some reformers and officials came to see this strategy as a systematic solution to the problem of the pauper stratum. This stratum was seen as an accumulation of degenerates breeding degenerates, a cancer to be surgically excised from the body politic.

Stedman Jones (1971:266-7, 307-10) connects an increasing emphasis on the forced emigration of paupers to the changing conception of poverty developing in a context of economic and social crisis during the 1880's. The pauper stratum were seen increasingly as the degenerate products of degrading conditions, capable only of breeding more of the same. Some reformers came to see the removal of this stratum as the only real option.

This opinion was far from universal. There were arguments, for example, that emigration only removed the best and most

salvageable of the pauper layer, leaving the worst problem intact (ibid. 104-5, 307-10). Emigration schemes were established, largely under the auspices of philanthropic bodies. While these were responsible for the transportation of large numbers of people, they were neither regarded as nor did they perform as complete solutions to the problem of pauperism[8].

One of the obstacles to these schemes was the development of independent labour policies in the imperial dominions. In Canada, official opposition to programmes of assisted emigration was crystallised by the recession of 1907-08. Unemployment forced a larger number of immigrants to seek relief. The number of immigrants deported as paupers jumped sharply. English immigrants were disproportionately represented among those deported. This raised official concerns about English immigration, and specifically the assisted emigration programmes Various barriers were introduced which eventually halted such programmes altogether[9].

Forced emigration, as such, did not figure prominently in British public health in the early twentieth century. In fact, forced immigration from Britain was more of a public health issue in Canada (and perhaps in other receiver nations) than in the 'mother country' at this time. The most damaged sections of the pauper stratum did remain a major problem for British officials. This was, after all, a group regarded as impervious to environmental conditioning. The impulse to drive out this group

remained, though forced emigration was not generally seen as a practical solution.

> When you have done your best you will still have left on your hands what I may term a residuum of the residuum, the hopelessly irreclaimable. They cannot be allowed to remain as plague spots on the community. They must be harried, driven out from one den into another, until they are finally disposed of either in the gaol or the workhouse (Swain 1903:126).

The slogan of sending the pauper residuum abroad to the colonies was replaced by the call to establish labour colonies within. A British official argued the need for, "...the segregation of the hopelessly defective as one segregates lunatics; the compulsory detention of the shiftless, the unemployable, in labour colonies..." (Pattin 1909:41). This penal approach to the pauper residuum was not central to public health programmes in practice, outside of the segregation of the mentally handicapped.

C. Immigration

Immigration played an important part in the formation of an industrial working class in England. Irish immigrants, along with women and expropriated members of the rural population, were used as low-paid unskilled workers to establish new lower norms of subsistence (in fact below the levels required to keep alive and raise the next generation). Engels (1969:123-4) wrote: "In short, the Irish have, as Dr. Kay says, discovered the minimum of the necessities of life, and are now making the English workers acquainted with it."

The dismal conditions of these Irish workers living at below subsistence levels made them vulnerable to the ravages of disease. Early public health picked up quickly on this correlation between areas with heavy concentrations of Irish workers and the presence of disease. Some officials blamed these epidemics specifically on the Irish population, as for example did one cited in Flinn (1965:15-16): "The Irish in Birmingham are the very pests of society; they generate contagion." This view was, however, dismissed by the most influential policy-makers such as Chadwick (1965:199):

> It is common to ascribe the extreme of misery and vice wholly to the Irish portion of the population of the towns in Scotland...It is to be regretted that the coincidence of pestilence and moral disorder is not confined to one part of the island, nor to any one race of the population.

The measures to deal with the problem therefore aimed at improving slum conditions rather than restricting immigration. This early discussion of the Irish posed for the first time the major question that continued to surround immigration and public health in Britain: were the dismal disease-promoting conditions that immigrants lived and worked under the products of basic racial characteristics or of circumstances faced after arrival?

The issue of public health and immigration focussed first largely on immigrants from Ireland, and later mainly on those from Eastern Europe. The flow of primarily Jewish immigrants from Eastern Europe to Britain began about 1880. The Royal Commission on Alien Immigration (UK.RCAI) attributed this

movement both to conditions inside Russia (economic factors and the increasing persecution of Jews) and to the draw of Britain.

> These two factors of expulsion and attraction are constantly at work, and supply the explanation of the immigration with which we are confronted (UK.RCAI 1903:4).

The Royal Commission listed a number of allegations against immigrants which were to be investigated in the report (UK.RCAI 1903:5-6, 19). These allegations provide a useful catalogue of anti-immigrant complaints in Britain.

The first group of complaints centered around conditions of public health. It was alleged that immigrants "...are impoverished and destitute...deficient in cleanliness, and practice unsanitary habits. Further, in the absence of medical inspections on embarkation or arrival, they "... are liable to introduce infectious diseases."

The second group focussed on the character of immigrants. These included a disproportionate number of "...criminals, anarchists, prostitutes and persons of bad character..." Many became paupers in Britain, seen as a moral failing.

The third group of complaints connected immigrants with the worst urban conditions. Immigrants tended to congregate in certain cities, particular in the East End of London. They "...caused the native dweller to be dispossessed of his house accommodation...", and generated conditions of overcrowding and rising rents.

The fourth group emphasized the economic impact of immigrants. Some claimed that local trades lost business due to

the tendency of immigrants to "exclusive trading", i.e. commerce within their own community. Immigrant workers were producing cheap articles "...under conditions as to hour of labour and rates of wages which are far below the standard acceptable to British workmen." This harks back to earlier comments on the Irish cited by Engels.

The final complaints were straightforward reflections of bigotry, complaining that Jewish people interfered with the Christian Sabbath, etc. All of the complaints were investigated by the Commission. The results of the investigation indicated a policy orientation very different to that employed in Canada. Degeneration was seen primarily as an internal problem generated by slum conditions rather than an external problem imported by immigrants. This policy difference reflected divergent priorities linked to the place of immigration within the social policy of each country.

In general, the British Royal Commission tended not to attribute the condition of immigrants to national or racial character, emphasising instead the circumstances they faced before emigrating, en route and in England. Immigrants were found not to be a significant source of infectious disease. Their lack of cleanliness upon arrival was connected to shipboard conditions as well as life habits. Poverty upon arrival was found not to be the rule, and was linked to impoverished conditions before emigrating (ibid:10-12).

The rate of pauperism among immigrants was found to be lower than among the population at large. Immigrants did not directly displace British workers or cause unemployment. Some immigrants certainly ended up working in dismal conditions, but the Commission did not directly blame them (ibid:15-20).

> ...we think it proved that the industrial conditions under which a large number of aliens work in London fall below the standard which ought, alike in the interest of the workman and the community at large, to be maintained (ibid:20).

The Commission did come up with a list of undesirable immigrants to be excluded. These were:

1. Criminals other than political.
2. Anarchists, and other persons of notoriously bad character.
3. Prostitutes and persons living on the proceeds of prostitution.
4. Persons affected by infectious or contagious diseases.
5. Lunatics or Idiots (ibid: 12).

Medical inspection at the border was to be introduced to screen out such undesirable immigrants (ibid:41). The Commission did not want to bar immigrants, arguing, "...it would certainly be undesirable to throw any unnecessary difficulties in the way of the entrance of foreigners generally into this country" (ibid:38). However, it was necessary to screen and select certain categories of immigrants.

> But we are of the opinion that in respect of certain classes of Immigrants, especially those arriving from Eastern Europe, it is necessary in the interests of the State generally, and of certain localities in particular, that the entrance of such immigrants into this country and their right of residence here should be placed under conditions and regulations coming within the right of interference which every country possesses to control the entrance of foreigners to it (ibid).

The major problems associated with immigrants in this report, though, were not the seeds of degeneration but conditions of overcrowding.

> But we think that the greatest evils produced by the presence of the Alien Immigrants here are the overcrowding caused by them in certain districts of London, and the consequent displacement of the native population (ibid:40).

The overcrowding of immigrants was seen as a special case of urban slum conditions, not resolvable through general social reform. "There seems to be little likelihood of being able to remedy these great evils by the enforcement of any law applicable to the native and alien population alike" (ibid). The centrepiece of the Commission's recommendations was the call for restrictions on the right of location of immigrants.

> We therefore think that special regulations should be made for the purpose of preventing Aliens at their own will choosing their residence within districts already so overcrowded that any addition to dwellers within it must produce most injurious results (ibid).

This plan did not provide much of a basis for policy. The restriction of settlement rights has, under certain circumstances been compatible with (or in fact central to) capitalist development (e.g. apartheid in South Africa). However, such mobility controls within a country cannot exist without a dramatic impact on the conditions of 'free labour' in the capitalist sense. Such mobility controls are unlikely in a developed capitalist country under 'normal' conditions, though that is not the central issue here.

The major point is that in Britain the question of immigration was seen as problematic in so far as it intensified

pre-existing urban problems, especially overcrowding. Absent were sweeping generalisations regarding racial or national character. Where in Canada there was a tendency to attribute urban problems as the working out of 'foreign' character, in Britain a concern over urban conditions predominated over cultural explanations.

This is not to say that racial issues were absent from British public health. To begin with, the fact that the immigrant overcrowding problem was identified as separate, requiring an independent solution, was a clear statement that racial or national issues were not ignored. Further, the committed eugenist current in British public health had very strong views on the question of immigration deriving from a profound commitment to theories of racial character. Barr[10] (1907:519) a leading public health eugenist, argued that the government was pursuing a dangerous policy of letting British workers degenerate while importing cheap alien labour.

> You can always keep up the population by importation of the alien. To such an extent is this policy being carried out that we are getting in all our large English towns the scum of Europe, and the flower of our rising generation is being driven to the colonies.

Such arguments were rare in Britain. There were few references in the public health periodical literature to issues of immigration or to questions of 'alien' racial character. These issues were more prominent in Canada than in Britain for two basic reasons. At the most obvious level, Canada was in an earlier phase of industrialisation in which the accumulation of a

working class was being accomplished through rapid urbanisation and massive immigration. It was possible in such circumstances to argue that immigration was the causal variable, even if it were not true. In Britain, the long history of urban industrialisation made any argument that social problems were either new or imported extremely dubious.

At a more profound level, the focus of British social policy was shifting in this period as discussed above. The working class, rather than the pauperised strata, was increasingly becoming the focus of that policy which was shifting towards economic and medical forms of regulation. This shift was moving public health away from a focus on issues of moral character, whether at the level of individual, race or nationality. This transition was in progress, and so its impact was as yet uneven. In contrast, this transition had not yet begun in Canada.

3.2.2. Canada: the 'Virgin Soil'

British eugenist Sir James Barr stated in an address to the Canadian Medical Association Annual Meetings:

> You have got here a young country, a virgin soil, and you should see that it is peopled by a vigorous and intellectual race. You should shut out all degenerate foreigners as rigidly as you would exclude a mad dog (cited Page 1912:26 and Bailey 1912:437).

Barr's views were relatively exceptional in British public health circles. In Canada, while his hard core eugenism was not widely held, his views of immigration resounded with those of many officials. His statement above was cited in articles by

Page, the Chief Medical Officer of immigration in the Port of Quebec, Canada's busiest immigrant reception centre, as well as by Bailey, an American public health official who worked alongside Canadians, inspecting immigrants routed through Canada to the United States.

The idea that Canada was a 'virgin soil', free of any native strands of degeneration, was prominent in public health and social policy in this period. Rapid industrialization was creating the need for many more workers, who were drawn largely through immigration from abroad. The heavy emphasis on immigration derived largely from the need to accumulate a working class (as well as rural labour and farmers) much more rapidly than the rate of biological reproduction would allow in a period of tremendous economic expansion, although other factors were also involved[11].

This external reproduction through immigration was largely unregulated in Canada through the nineteenth century. The extent of state regulation increased dramatically in the early twentieth century. This increased regulation included recruitment programmes overseas, the selection of immigrants through medical inspection, and programmes to promote assimilation in urban centres.

Public health played a major role in this expanding regulatory regime. Medical inspection, governed by public health criteria, was the first important method for selecting immigrants. Local public health officials played a significant role

in promoting the assimilation of immigrants through such programmes as: visiting nurses, education in the schools and child welfare. This orientation to the regulation of reproduction through immigration derived from the basic goal of public health to enhance national peace and prosperity through the development of a healthy and efficient working class.

Public health officials viewed immigration with tremendous ambivalence. On the one hand, it was seen as the absolutely essential source of labour required for continued economic growth in Canada. On the other, it was seen as the major source of social problems which threatened the health and efficiency of the working class. The aim of public health in this field was to attempt to promote immigration while excluding or eliminating the problems through effective screening and active assimilation. Bryce (1912:689) put this goal when he wrote:

> None, I think, can imagine that any attempt to turn back the veritable flood of immigrants from Canada is either necessary or desirable; but rather that all should be determined that we shall encourage to come only those who will be a social asset of real value as well as source of material wealth.

Public health officials in turn of the century Canada regarded degeneration as a preventable imported problem. The aim was, in the words of a Toronto Globe editorial cited in Public Health Journal (1913:374), "...to prevent the evils that have hampered and oftentimes wrecked the nations of Europe." Providing that action was prompt, Canada could benefit from the bad experiences of Europe and the United States and prevent the problem of degeneration from taking root (e.g. Bryce 1912:686).

Degeneration was regarded as a product of living and working conditions in the cities of Europe which could be carried into Canada by immigrants, much like a contagious disease. Bryce wrote that degenerative effects were seen in those who "...have been for several generations factory operatives and dwellers in the congested centres of large industrial populations" (Canada.Interior 1909:110, cited in full p.185). Public health officials aimed to prevent degeneracy from taking root in Canada first through excluding 'infected' immigrants and secondly through improving urban conditions to check the development of environments in which degeneration might thrive.

Urban industrial conditions were clearly seen as the source of degeneracy amongst immigrants. Canadian public health officials in this period favoured immigrants from rural backgrounds who settled in rural situations. This corresponded with the general emphasis in Canadian immigration at the time to attract settlers and agricultural labourers, particularly in the West (e.g. Canada.Interior 1906:ix). There was, however, a contradiction between the official policy of attracting agriculturalists and the reality that many immigrants became industrial workers (Avery 1979:7-9). In fact, as Bryce (1912:686) among others clearly pointed out at the time, the urban population in Canada was growing far more rapidly than the rural.

Great concern was expressed by public health officials regarding the number of immigrants settling in urban centres.

Bryce (1912:688-92) argued that it was necessary to ensure that a majority of the Canadian population remained agricultural through "...steps to lessen this abnormal and insane urban influx by turning this mass of human energy back to the land." Clarke (1919:443) was even harsher:

> ...the immigration went, not to the land where it was required, but to the urban centres where it was not either desirable or particularly beneficial. As a matter of fact, the poorer mental types gravitate to cities where they find conditions of squalor and poverty to which they are accustomed.

This rather romantic tendency to counterpose desirable rural settlement to undesirable urban growth was common in the public health literature, despite the fact that it flew in the face of political and economic reality. An unsigned article in Conservation of Life (1914:30-1) stated that such pro-rural arguments seemed theoretically unassailable, but ignored important considerations:

> Speaking generally, therefore, we may say that the movement of population cityward is determined by economic and social causes which it is impossible to resist, and that our policy must endeavour to regulate rather than dam back this flow.

This pro-ruralism created contradictions in another area. Public health officials, along with other state policy-makers, tended to favour immigrants of British origin on the grounds of cultural and racial compatibility[12]. Yet these were the very immigrants who were most likely to come from urban situations and to bear the mark of degeneracy.

This put public health officials in a difficult position. They tended to sound surprised, and in some cases almost apolo-

getic about their repeated finding that British-origin immigrants were the most likely to show signs of degeneracy:

> It is no criticism of the British people to say that a large proportion of the immigrants, even from the Old Country, are not good stock from which to build up a new citizenship (Conservation of Life 1919:37, see also Bryce 1908:390 & Clarke 1916:462-3).

This led some public health and state officials to openly conclude that non-British immigrants of peasant background were the most desirable. Clifford Sifton, Minister of the Interior 1896-1905 and later chair of the Commission of Conservation went on the record repeatedly as favouring the immigration of:

> "...the stalwart peasant in a sheep-skin coat, born on the soil, whose forefathers have been farmers for ten generations, with a stout wife and half a dozen children... (Sifton 1922:16, see also Canada.Interior 1902:7).

Bryce (1913:641-2) endorsed this view. Yet, it ran against the current of Anglo-Saxon chauvinism in state policy circles. Officials like Bryce attempted to reconcile the 'moral superiority' of the Anglo-Saxon race with the relative deficiency of British-origin as opposed to non-British immigrants:

> Can it be a law in morals that the most unmoral races are the least immoral in those ethical qualities which bring them within the causes of deportation under the Immigration Act, as pauperism, crime and disease? (Canada.Interior 1914:180).

The difficulties of rural non-British immigrants in adjusting to urban conditions in Canada were pointed out by some (e.g. Plumptre 1914:27, Shaver 1916:433). Public health in Canada was left with a contradictory position; favouring British immigrants on the grounds of cultural integration and chauvinism, while

recognizing that these were the most likely to bear with them the conditions of degeneracy.

The regulation of immigration was central to the project of nation-building in early twentieth century Canada, as conceived in terms of race degeneration. Broad views of national character played an important part in this regulation. In Britain, such views were already giving way to a different kind of analysis linked to economic and medical social policy. In Canada, this transition was not yet underway. Public health officials were at the leading edge of state policy-making in defining immigration as a central problem of social policy. They did this using theoretical tools with a heavy emphasis on moral conceptions such as national character. These conceptions left officials with rather contradictory views of which types of immigrants were desirable.

3.3 Case Study 1: The Regulation of Immigration in Canada

The selection of immigrants at the border was an issue of paramount importance for Canadian public health in the early twentieth century. There were two reasons for this. First, immigrants constituted a significant proportion of the Canadian working class in this period, and so the health, skills, morals and discipline of the class as a whole depended largely on the quality of its immigrant members. Secondly, it was specifically believed that the problems of urban industrialism could be avoided in Canada provided that degenerates produced elsewhere were strictly screened out.

The selection of immigrants was accomplished through medical inspection which was introduced in 1902 and fully implemented over the following few years. The core of medical inspection was a visual examination of immigrants arriving at seaports. On the basis of this examination, medical inspectors could either allow immigrants to enter, detain them for treatment, or exclude them from Canada. Immigrants could also be deported for medical reasons after admission to Canada.

The medical inspection of immigrants represented the first major attempt to screen and select immigrants to Canada. Previously, quarantine measures had been in place to prevent the entry of people with contagious diseases through the use of detention[13]. Medical inspection, in contrast, aimed to identify and exclude unsuitable immigrants.

The 1872 Immigration Act governed immigration to Canada up to the turn of the century. Bilson (1984:399) wrote that the 1872 Act, "suggests that the immigrant was not much feared as a danger to health." This began to change around 1900.

The first major revisions to the 1872 Immigration Act were in 1902 and 1906. These revisions for the first time absolutely excluded certain categories of immigrant (ibid:399-400). It was no longer the diseases they might carry, but rather the nature of the immigrants themselves that became the public health question. Bilson (1984:409) wrote:

> In 1872 the assumption was that Canada could absorb and use all those who were not suffering from quarantinable disease and not likely to become a public charge. The debate over immigration in subsequent years was shaped by racial assumptions and by the growing strength of the idea that certain kinds of disease were hereditary and consequently a danger to the community at large.

Medical inspection was first introduced with a vague medical definition of unsuitable immigrants. Those suffering from a "loathsome, dangerous or infectious disease or malady" were to be excluded or detained for treatment (Canada. Interior 1904:148-150). Over time, the definition of unsuitable immigrants was made increasingly specific and decreasingly medical through legislation and Orders-in-Council. However, even these more specific criteria for the exclusion of immigrants remained highly contentious and allowed for a great deal of official discretion.

The problem was that medical inspection was not simply attempting to screen out immigrants who were ill according to specifically defined and objectively verifiable medical criteria.

Rather, the aim was to screen out unsuitable immigrants according to a range of medical, social and economic standards. These standards were anything but clear, and at times were obviously contradictory.

This is not to say, however, that the criteria for medical inspection represented an eclectic mish-mash of contending standards. Medical inspection was guided by a body of public health theory brought by Dr. P.H. Bryce, the Chief Medical Officer and probably Canada's foremost public health official at the time[14]. This theory was not static, but changed substantially during the period in which it was used as the primary basis for selecting immigrants to Canada. These changes had two sources.

At the most general level, broad changes in the orientation of public health were reflected in the theory and practice of medical inspection. In the earliest period of inspection, old sanitarian concerns were nudged aside, replaced by criteria derived from the new hygiene linked to theories of race degeneration. At the end of this period, public health criteria themselves were replaced by directly medical, economic and political definitions of acceptable immigrants. The broad history of public health in transition from the old sanitarianism to the new hygiene to marginalisation under the regime of economic and medical social policy was played out at the level of immigration policy.

More specifically, the theory and practice of medical inspection changed in response to particular problems in the definition of the desirable immigrant. On the one hand, prevailing conceptions of cultural compatibility and racial superiority pointed to the desirability of Anglo-Saxon (British or Anglo-American) immigrants. On the other hand, environmentalist theories of race degeneration indicated that immigrants exposed to urban, industrial conditions (especially the overwhelmingly working class emigration from Britain) were the most dangerous. Policies and theories changed as officials worked their way through these contradictions.

The theory and practice of medical inspection changed, then, in response to broad developments in public health and to specific issues in the definition of the desirable immigrant. Medical inspection focussed initially on eye diseases, a product of poor sanitary conditions on shipboard which was connected to cultural backwardness. The focus shifted to the identification of mental conditions regarded as indicators of race degeneration. Finally, towards the end of this period, civil (i.e. non-medical) criteria increasingly predominated. This general movement should not be seen as a clear-cut succession of three periods, but rather as the uneven process of shifting priorities in a moment of transition.

3.3.1 Physical Indices of Cultural Conditions

The medical inspection of immigrants to Canada was first introduced in 1902, through an amendment to the Immigration Act. J.A. Smart, Deputy Minister of the Interior, described the purpose of the amendment as; "...the enforcement of such regulations as might be necessary to prevent the landing of undesirable immigrants" (Canada.Interior 1903:xxxii). This measure was aimed at screening out undesirables among immigrants of non-British origins (i.e. from neither Britain nor the United States). Smart (ibid) wrote:

> The department has of course experienced no difficulty in guarding against the entry to Canada of undesirable settlers from the United States, as such settlers are always of a desirable class. It is deemed advisable, however, to take necessary steps to exclude foreigners who might be brought in from continental countries suffering from dangerous, loathsome or infectious diseases, or not possessing sufficient means to maintain themselves.

The focus on 'foreign' immigrants in the initial development of medical inspection reflected a clear preference for immigrants from Britain. Early in his tenure, Bryce wrote in an article on medical inspection:

> It must be apparent to all that when a British community in any part of the world takes up the problem of filling its unoccupied lands with settlers it most naturally looks to older Britain for its supply in preference to any foreign country. Such a colony is assured of receiving a people possessed of the same ideals, religious, social and political... (Ont.PBH 1904:105).

Medical inspection was not intended as a simple screening of all immigrants along health lines. Rather, it aimed to exclude 'foreign' (i.e. non-British origin) immigrants who suffered from specific diseases or were otherwise undesirable. Health was the identified criterion, though suitability was the persistent

concern. The concerns about the suitability of specific national groups were overt. Bryce's reports were peppered with tables and statements comparing health on the basis of nationality.

Bryce's initial 'Instructions for the Medical Inspection of Immigrants'(reprinted in his first annual report, Canada.Interior 1904:149-50) reflected an intention to screen these 'foreign' immigrants around a wide range of criteria. In that document he identified three classes of immigrants to be identified through inspection.

Class 1 consisted of, "...persons who by some reason of specified disability or disease, or through some moral or criminal cause, are refused admission to Canada." These were (in the language of the times): convicted criminals, the insane, epileptics, idiots, blind, deaf, dumb and other defectives, advanced consumptives and those with chronic venereal diseases.

Class 2 consisted of, "...persons who by reason of being diseased, crippled or deformed or through some mental condition, must be held for examination as to whether the conclusion 'that they are likely to become a public charge' can be justified." This included those with dangerous contagious diseases (e.g. smallpox), those with diseases which might be chronic but were not necessarily life-threatening (e.g. trachoma, favus, heart disease) and those who were crippled or deformed.

Finally, Class 3 immigrants were, "...persons who, suffering from some physical disease of a curable character, may be admitted for treatment in a detention hospital under the super-

vision of the department..." This included those with mild contagious diseases or other treatable conditions.

These Instructions reflected the priorities of public health theory at the time. The primary concern was to avoid importing the elements who might form the basis of a destitute class and threaten the physical, mental and moral health of the nation. This would require quite a comprehensive and effective inspection.

In practice, however, the aims of medical inspection in its early years were considerably more modest. The focus was primarily on the detection of eye diseases. Eye diseases accounted for the vast majority of those turned back at the border (rejected) until 1907, and a majority until 1909 of those detained for treatment or assessment[15]. This was in part because those conditions which theoretically were to be most strictly excluded were often the most difficult to detect. Bryce wrote in his first report (Canada.Interior 1904:169):

> It is evident that there are diseases, such as epilepsy, insanity, incipient tuberculosis, all of the greatest importance, yet of which cases, in the necessarily rapid examination of the hundreds coming off a vessel, will not infrequently pass unrecognized.

Of course, these practical problems in detecting other conditions do not explain the focus on eye diseases (particularly trachoma). Eye diseases were central to the introduction of medical inspection in Canada. Smart (1903:6) told a House of Commons committee why medical inspection was introduced:

> ...a great many complaints...were made as to immigrants arriving in Canada afflicted with certain diseases

> [trachoma, favus and one or two others]...which, in the opinion of the United States quarantine, should be kept out of the country. Our quarantine officers never considered these as dangerous diseases...

Smart specified that trachoma was "...about the only disease there seems to be any danger with" (ibid). Medical inspection, then, was introduced largely to bring Canada in line with American standards regarding the screening of immigrants for specific diseases, particularly trachoma. This still does not explain why screening for trachoma was seen as a useful method of selecting suitable immigrants and excluding undesirables.

To begin with, the prevalence of eye diseases among immigrants was connected with sanitary conditions aboard the ships used to travel to Canada. Bryce noted this in a comment on the high proportion of Asian immigrants rejected for eye diseases.

> ...the fact that so many are detained at the ports indicates the tendency before commented upon to the development of ophthalmia during the long sea voyage, owing often to overcrowding and exposure to foul and infected air in the holds of ships, to common washing utensils and infected towels (ibid 1907:126).

The high incidence of eye disease was quite specifically linked to conditions on the sea voyage rather than the prevalence among immigrants before setting out. The previous year (1906) he had written:

> ...as both at Antwerp and Hong Kong, every emigrant is certified free from disease, the conditions on shipboard during the long voyage must be the explanation of so many cases of infective conjunctivitis (ibid 1906:123).

Bryce, then, saw eye disease as a contagious medical condition which thrived in the unsanitary conditions of immigrant

ships. In this sense, the focus on eye disease can be seen as a growth out of old sanitarian concerns for shipboard environments, dating back to the mid-nineteenth century[16]. Yet this old concern was merged with newer issues arising out of the new hygiene and broader race theories.

Trachoma (as well as related eye disease)[17] was seen as a condition only affecting 'foreign' immigrants. The incidence was highest among Continental Europeans and Asians (Canada.Interior 1905:127). Bryce (1908:393) told a House of Commons committee that British immigrants were not even checked for eye disease. He explained that trachoma was not found among immigrants from England, "...except a few Jews from the East End of London" (ibid:401).

Bryce noted his first annual report that trachoma was contagious and prevalent amongst certain peoples of Europe. He cited sources linking trachoma to blindness, and to bad sanitary conditions. He then stated:

> From the history, as well as the character, of the disease, as being due to its specific germ or microbe, it is apparent that the migration of these people to America, bringing with them their own customs and habits of life, becomes a matter of importance and demands just such actions in the interest of the public as it is shown has been taken at the Canadian ports of entry (Canada.Interior 1904:168, also 1914:172).

The threat of trachoma, then, was linked to the way of life and hygienic habits of immigrants of non-British origin. The next year, Bryce made this connection more explicit when he stated that eye diseases "...occur especially in those classes who from

other standpoints are often undesirable...(ibid 1905:134). His clearest statement regarding trachoma was in 1906:

> Its importance is great, not alone as a communicable disease to be excluded, but because it is in a large measure the index of the low social condition of the sufferers from it (ibid 1906:119).

Eye disease, then, was not simply a medical problem in any narrow sense. It was an index, marking potentially less desirable immigrants. It provided officials with a basis for further investigation of these suspect immigrants:

> The detention on account of [eye] disease fulfills quite accidentally another most important requisite, that of a closer observation of the moral and mental type of the immigrant (ibid 1905:127).

Through this observation, it was possible to make an assessment, "...as to whether the immigrant is not only readily curable of his disease, but also whether he is in other respects desirable" (ibid:128). Detention also served to give women and children a much needed rest after the voyage, "...while their education into the relatively sanitary modes of house-life in Canada is in itself important" (ibid 1906:123).

Thus a medical condition linked to shipboard sanitary conditions served as an index of cultural backwardness and an indicator of the need for hygiene education. To an extent, the concerns of the new hygiene were overlayed onto a traditional sanitarian issue. This overlay led to a tension in the way eye disease was discussed in Bryce's reports.

He could write, for example, that the high detention rate for Japanese immigrants was an index of their undesirability:

> ...the fact that 1 in every 2 Japanese was detained at Victoria and 1 in 54 deported and at Vancouver 1 in 3 detained and 1 in 10 deported indicates not more the exactness of inspection than the need for every precaution being taken to prevent the entry of what evidently is on the whole an inferior type of immigrant (ibid 1907:126).

Yet he would go on and explain this incidence in terms of shipboard sanitation (ibid., cited above). He was proud of the effective treatment of eye disease in the immigrant detention hospitals run by his department (ibid 1906:123). He expressed compassion for the immigrants detained for treatment, recognizing the financial burden it placed on them and admiring their courage (ibid 1905:134). He saw hygiene education as a solution to a condition linked to habits of life (cited above).

Yet, in the early years of medical inspection, eye disease served to flag particularly suspect individuals among the immigrants from those sources which were regarded as most problematic, Continental Europe and Asia. These suspect immigrants were detained for observation, assessment and education.

The centrality of eye diseases in medical inspection began to decline. In 1906, Bryce reported a 'notable reduction' in the proportion of detentions based on eye disease. He attributed this to stricter supervision at the ports of departure (ibid 1906:123). This decrease occurred first amongst European immigrants arriving at Atlantic seaports (ibid 1907:130). A notable decrease in the detention of Asian immigrants for eye disease was reported in 1909 (ibid 1909:108).

In 1908, Bryce (1908:398) announced success in the anti-trachoma campaign to a House of Commons committee: "I wish we

could prevent other diseases as easily as we have been able to stamp out trachoma." In fact, he was somewhat premature. The number of detentions for eye disease actually increased in 1909-10, though this increase was seen as an anomaly by Bryce, due to the conditions on the ships of a new line carrying immigrants (Canada.Interior 1911:118). After 1910, Bryce reported a consistent decline in detentions and rejections for eye disease, though they remained a significant factor in the rejection and detention of immigrants until World War I dramatically reduced immigration by sea (ibid 1911:118; 1912:127; 1913:139; 1914:172; 1915:12).

The shift away from an emphasis on eye diseases in medical inspection was not just a matter of victory in the anti-trachoma campaign. It marked a serious reorientation in medical inspection. The whole conception of the unhealthy and undesirable immigrant changed. No longer was it simply the 'foreign' immigrant who might be undesirable. British and American immigrants, many of whom came from highly urbanised settings, were also to be inspected and regarded as potentially unsuitable. The medical criteria defining the undesirable immigrant changed significantly, from eye disease as an index of cultural backwardness (and/or poor sanitation on ships) to such conditions as mental handicap, pauperism and moral turpitude as indicators of degeneration.

There were two bases for this shift. In an immediate sense, the recession of 1907-08 marked a major turning point in the

inspection of British and American immigrants. Unemployment forced a larger number of immigrants to seek public assistance. The number of immigrants deported as paupers jumped sharply. English immigrants were disproportionately represented among those deported. This raised concerns about English immigration, and specifically the assisted emigration programmes sponsored by philanthropic bodies (ibid 1908:xxvii-xxix,63,127-36; Glynn 1982:223).

The beginnings of this shift predate this recession, however. Greater scrutiny was directed towards British immigrants as early as 1906. At a broader level, this shift was connected to the general transition in public health in this period. The centrality of eye disease as a criterion for unsuitability could be seen as the overlay of new hygienic questions onto old sanitarian concerns about eye disease and the environment on board ships. Now, new criteria were developed which reflected in a purer form the contours of the new hygiene and concerns about race degeneration. It was those conditions most directly linked to race degeneration under urban industrial conditions (mental handicap, pauperism, immorality) that were now taken to be indicators of undesirability.

3.3.2 Indications of Degeneration

Central to the degeneration theories which moved to the heart of early twentieth century public health was the idea that urban conditions were creating a dangerous moral decline in the

working class. Insofar as there was an actual physical decline in the working class, this was seen largely (though not exclusively) as the result of this moral failure. As medical inspection shifted towards the exclusion of immigrants bearing indicators of degeneration, it was those conditions associated with moral failing which were specifically sought out. These included mental handicap, pauperism, sexually transmitted diseases and criminality.

A. Mental Handicaps

Mental handicaps were seen as a prime mark of moral degeneracy. They had been included as criteria for exclusion in Bryce's initial 'Instructions for the Medical Inspection of Immigrants'(reprinted in his first annual report, Canada.Interior 1904:149-50). However, in his first two reports, the consideration of mental handicaps was essentially limited to pointing out how difficult they were to detect through inspection (ibid 1904:169-70, 1905:133-4).

The next year was the first in which substantial attention was devoted to mental handicaps. Bryce announced an increase in the number of patients detained for nervous disorders (insanity, epilepsy, etc.) from 14 in 1904-05 to 28 in 1905-06:

> This is due in large degree to the more strict observation extended, especially to British immigrants, during the past year, as it is found that by far the largest number of those detained in this class were English (ibid 1906:123).

As the exclusion or deportation of immigrants classified as insane became an increasing priority for medical inspection, the

scrutiny of British immigrants became more important. After all, Britain was the birthplace of urban industrialism and all the conditions associated with it. Bryce had written early in his tenure as Chief Medical Officer responsible for immigration:

> We are thus brought face to face with the fact that the British immigrants we are so assiduously cultivating must in large measure be urban in character (Ont.PBH 1904:108).

A two-fold concern about mental handicaps was expressed in Bryce's annual reports. The first was economic: "...the insane and idiot are the most serious burdens to the state..." The second related to the broad social and moral impact:

> ...there is on every side, amongst his patients, the constant reminder to the medical man of the perpetuation of hereditary neuroses in many forms, and which under the stress of modern life are in the older civilizations, whether of Europe or America...directly affecting the literature, morals and general character of society (ibid 1906:124).

This statement reveals the contours of Bryce's view of insanity (and similar mental handicaps). First, insanity was hereditary, yet problematic due to environmental conditions. Secondly, it was a threat to 'the general character of society'. Exclusion, then, was doubly important. On the one hand, those who bore the hereditary predilection to insanity could be kept out, preventing the introduction of insanity into the 'national stock'. On the other, the vicious cycle of degeneracy (in which insanity affected the moral character of society, exacerbating the threat of insanity) could be avoided.

In Bryce's terminology, 'modern life in older civilizations' meant urban life in Europe. He described dementia praecox as the

type of insanity, "...which expresses the unbalanced mind, the outgrowth of the degeneracy peculiarly the result of modern urban and social conditions in so-called civilized countries" (Bryce 1913:646). While it was regarded as a hereditary condition, insanity was also inextricably linked to the urban condition, particularly in Britain.

Initially, the mental handicap primarily regarded as an indicator of degeneracy was mental illness (or 'insanity' in the language of the times). Later, the admission of people who were mentally handicapped ('mental defectives' or 'feeble-minded') became a focus of attention as well[16]. Mental handicap was seen increasingly as a condition underlying a range of urban social problems. Bryce wrote that "...mental studies of criminals in institutions are making it clear that it is the mental defectives that form the majority of such classes..." (Canada.Immigration 1916:28). His contemporaries went much further, picking up American eugenist arguments. Just one example is provided by the following claim:

> In short, the more we study the more we find that the great majority of those who go to make up the social problems of our cities and towns can be demonstrated to be feeble-minded (Sutherland 1915:176, see also Reid 1913b:287).

While Bryce increasingly argued for vigilance against the admission of people with mental handicaps, he also urged some caution. At a time where statistics demonstrating the large number of 'foreigners' in mental institutions were commonplace in the public health literature, Bryce argued that the rate of deportations for insanity among immigrants was lower than the

rate in the national population (Canada.Interior 1914:180). He further argued that the required accurate study of immigrant inmates in institutions had not been done (ibid 1916:82). He also wrote that families including a mentally handicapped person need not necessarily be excluded from Canada:

> ...the benefits of new opportunities in Canada for personal and family advancement, financially and socially, should not be withheld from worthy families, at least of British descent (ibid 1915:9).

Nevertheless, he saw the exclusion of people with mental handicaps as a priority. The problem was that there were real limits on what could be done through medical inspection to address these problems. The difficulty of detecting people with mental handicaps at the borders was stated revealingly by Page (1915:556-7), who was Chief Medical Officer of the port of Quebec (Canada's busiest port for immigration) under Bryce:

> ...[the medical inspector] has to make due allowance for racial characteristics and the emotional state created in so many of those primitive foreigners by the new environments, etc. At times it becomes a very difficult matter to distinguish among the latter, between ignorance and moronism.

Bryce (1908:391) estimated that a really thorough medical inspection would require the detention of whole arriving shiploads for three or four days. The pressure of numbers was a very real limit on more thorough inspection. One thing Bryce could do was instruct his inspectors:

> What we have done has been to insist upon our medical officers opening their eyes wider, if possible, to see any mentally defective persons (ibid).

Bryce also called for measures to incorporate shipboard medical officers, who were shipping company employees, as ancillary medical inspectors (Canada.Interior 1908:114). The following year a form was introduced in which the ship's medical officer was required to testify that the passengers on board had been regularly inspected (ibid 1909:100). He attributed increasing success in detecting insane and epileptic immigrants who were "not likely to be discovered during the brief examination on landing" to the "work done by ships' medical officers" (ibid 1911:118). He wanted to go still further, to paying the ship's medical officers a bonus for doing thorough shipboard inspections (ibid 1913:139).

Bryce also called for "an expert inspector on nervous diseases" who would be "highly paid" to detect cases of mental handicap at the border (ibid 1913:139). Despite some measures taken, the problem of detecting immigrants with mental handicaps was "...so serious as to demand an immediate and prompt measure for the remedy of more and better inspection of this class of cases (ibid)".

There were real limits on the extent to which inspection at the border could be upgraded, especially to detect relatively invisible mental conditions. Deportation, therefore, assumed increasing importance in the practice of medical selection as degeneration disorders were increasingly emphasized. Bryce (1908:404) agreed with a member of the Select Committee on Agriculture and Colonization who stated, "...in all your inspec-

tion the most valuable thing you have is the provision that you can deport..."

The criteria for detention or rejection at the border and those for deportation after admission were somewhat different. Immigrants were deported, particularly after the 1906 Immigration Act[19], on the grounds of becoming a public charge within two (and later three) years of arriving in Canada. As seen above, immigrants were detained or rejected largely on the basis of having some condition easily identified through a superficial visual inspection.

In the early years, British immigrants were largely overlooked in medical inspection. They were, however, subject to deportation after admission for medical causes. In his first report as Chief Medical Officer, Bryce pointed out, "...the relatively high proportion of British immigrants that have been deported..." (ibid 1904:169). This finding was repeated year after year. While non-British immigrants tended to be detained or rejected at the border, particularly due to the detection of eye disease, it was primarily British-origin immigrants who were deported after admission[20].

In order to ensure that all immigrants who became public charges were deported, officials such as superintendents of institutions and municipal clerks were required to provide increasing amounts of information on immigrants who were sick, insane or destitute (ibid 1907:134, 1908:110, 1909:101). Bryce

(1908:400) stated, "...we have hunted the hospitals and asylums since the [1906] Act went into force..."

Despite measures taken to improve the effectiveness of procedures for excluding or deporting immigrants with mental handicaps, there was a great deal of criticism of medical inspection in the public health literature. Critics[21] included: J.W.S McCullogh (1917:34-5) the Secretary of the Provincial Board of Health in Ontario, C.K. Clarke (1916:462) the head of the Toronto Psychiatric Clinic and A.H. Desloges (1919:3-4)the General Medical Superintendent for the Insane Asylums of the Province of Quebec. These critics argued that medical inspection was inadequate, calling for more thorough investigation at the border and better screening of immigrants back home before being accepted as immigrants.

B. Moral Disorders: Pauperism, Criminality and Venereal Diseases

The other disorders associated with degeneracy that Bryce discussed in some detail were pauperism and criminality. He saw these conditions as related products of urban conditions. The greatest culprit in promoting these conditions was the English Poor Law.

The overly generous provisions of the Poor Law contributed to the development of moral characters likely to succumb to public dependency. Bryce counterposed the British, "who seek aid through habit", to the Italians "who live in communal groups [and so] seldom seek assistance" (ibid 1914:178). He similarly pointed to self-help in the Jewish community (ibid 1907:135).

Bryce first discussed the Poor Law in his first annual report. Not only were British immigrants unaccustomed to pioneer conditions, but they were also taught by poor law institutions "...to resort, when ill, to these institutions as a matter of course." Continental Europeans, in contrast, were used to a "ruder and less humane social life" and "more content to wear patiently their ills, either physical or social". Nevertheless, he warned against drawing conclusions unfavourable to British immigrants (ibid 1904:170).

Seven years later, Bryce was harsher:

> the British Poor Law has for four centuries become so integral a part of the social fabric there that immigrants brought up under its influence have, when in need or distress or sick, without hesitation drifted to the refuges, houses of industry or hospitals in Canada as naturally as they did in England (ibid 1911:127).

He went on to warn in no uncertain terms against such an "abuse of charity" in Canada, which would result in the "creation of a dependent class". On one level, Bryce did recognize that unemployment was a product of economic circumstances. Yet he felt that only the less determined would fall victim to it. He wrote that prior to the 1907-08 economic depression, "all of those on arrival who desired work obtained it." The depression, however, "caused a stoppage of work" which affected "the least desirable and energetic immigrants, especially in Ontario" (ibid 1908:127). Many of these became public charges and had to be deported.

Yet, only a minority succumbed to dependency:

> That there should have been in the stress of a sudden stoppage of work during a Canadian winter so few cases subject to deportation...is probably the best commentary possible upon not only the industrious qualities of our immigrants, but more upon their moral characters (ibid 1908:129).

Those trained by the Poor Law to "seek aid through habit" were most likely to succumb in such circumstances, as were other victims of degeneration. It was not only British immigrants who were seen as most likely to become paupers. Bryce also saw American immigrants as a potential source of degeneracy. In 1908, Bryce wrote that his previous calls for medical inspection along the United states border had been backed up:

> At all points along the boundary the unemployed, not infrequently of an undesirable class physically, mentally and morally, have entered Canada, and some have found their way into charitable institutions and others into our common jails (ibid 1908:116).

Action to deal with this situation was, "...as necessary from the medical standpoint as from the social and economic" (ibid 1908:116). It was not simply a question of temporarily unemployed people moving into an already crowded labour market to seek employment. Rather, there was a high likelihood that unemployed people were physically, mentally or morally degenerate.

Bryce saw the tendency of British and American immigrants to seek aid as a product of material, social and cultural environments. He wrote, for example of other ethnic groups which were beginning to show a resemblance:

> ...if not to the physical weaknesses of the English-speaking peoples, at any rate to their social customs in the matter of urban living, and the parasitic habits which seem inevitable to it (ibid 1914:180).

In contrast, he tended to see criminality more as an individual hereditary trait:

> Had it been possible to analyse more closely the cases deported as public charges for criminality, immorality and vagrancy, it would have been proven that underlying in many, indeed most, of such individuals were hereditary influences which worked as a poison in the blood to counteract the effects of often good environment(ibid 1914:177-8).

Criminality was not, for Bryce, merely a question of convictions in court. In one example, Bryce counted as members of the criminal class, "... 11 criminals, 4 suspected immoral, 8 prostitutes, 30 of bad character, 1 procurer, 3 degenerates, 2 elopers" (ibid 1907:131). These were people of particularly vicious moral character who were products of bad stock and likely to reproduce more of the same.

Sexually transmitted diseases emerged as a key public health issue toward the end of this period. The control of immigration was again regarded as a crucial component of the solution to the problem. An Ontario Royal Commission investigating sexually transmitted diseases wrote:

> Obviously any attempts to repress venereal diseases would be seriously hampered if immigrants infected with it were allowed to enter Canada freely...Naturally, there should be medical inspection at the port of entry by a staff specially educated for the purpose, and resolute refusal to allow a single individual to land who is either a present or potential carrier of venereal infection (Ont.RCVDFM 1919a:4).

The exclusion of 'present or potential' carriers of sexually transmitted diseases was a tall order, though one that fit with the general trend towards moral screening. Small numbers of immigrants were rejected (at the border) or deported (after settling in Canada) for sexually transmitted diseases, prostitution or immorality (e.g. Canada.Interior 1919:22-3, 1915:11). Moral screening along the lines of sexual regulation remained a proportionately small but ideologically significant part of medical inspection, to some extent overshadowed by the emphasis on mental handicaps and (actual or potential) pauperism.

C. Borderline Degeneracy: Physical Handicaps and Tuberculosis

Bryce operated with quite a rigorous definition of what constituted degeneracy, deriving from widely held theories in public health and social policy. In those categories characterized by moral degeneracy, he advocated consistent and unequivocal exclusion or deportation. Other categories, such as

tuberculosis and physical handicaps, might or might not be taken as indicators of the physical impact of degeneration.

Physical handicaps were to be investigated on a case by case basis to investigate whether or not degeneracy was a consideration. Regarding the decision as to whether or not a physically handicapped person should be allowed to stay, Bryce wrote:

> The personal equation, that of the character of the individual person and his family counts for much; while naturally occupation and destination enter into the problem. Suffice it to say that it is the most important as well as most difficult of all the problems of medical inspection, and demands not only medical judgement but a good knowledge of its bearing on the wider social problems Canada will have increasingly to deal with (ibid 1906:124).

The following year he wrote that one of the factors to be considered in such cases is the presence of a family who can not only support the immigrant, but "...whose general well-being indicates the absence of degeneracy" (ibid 1907:131). In short, physical handicap might or might not indicate degeneracy. The preservation of an effectively functioning family was far more important than the exclusion of a condition that did not necessarily bear the threat of degeneration.

Similarly, cases of tuberculosis were to be considered on an individual basis. Tuberculosis was a major public health concern in the early twentieth century. In Canada, tuberculosis was seen, at least in part, as an immigrant problem. Yet, Bryce argued consistently against the view that it should be seen as an imported problem.

He wrote in an early report that relatively few immigrants were deported due to tuberculosis, "...several times less per

1,000 than they would be in a similar number of the resident Canadian population" (ibid 1904:170). In 1907, Bryce reported an increase in the number of tuberculosis cases detected from four to fifteen, which was still only a tiny proportion of the 3,543 immigrants detained (ibid 1907:121-29). The 1907 report also saw a discussion of tuberculosis and immigration aimed at debunking myths that tuberculosis was being brought into Canada by immigrants.

Bryce began the discussion by explaining again the difficulty of detecting tuberculosis cases through medical inspection:

> How a tuberculized person told to keep on deck in the fresh air, should with sunburning and an appearance of ruggedness be overlooked will readily be understood...(ibid 1907:129).

While admitting these difficulties, Bryce went on to challenge the implications of submissions to the federal government by the Toronto and Montreal Boards of Trade noting the high proportion of foreign-born patients in tuberculosis sanitoria. He conducted further research, finding that only a small proportion of these foreign-born patients were recent immigrants. Of those, only a very small number were likely sick when they entered Canada. He concluded by noting the small number of immigrants who had been rejected or deported from Canada due to tuberculosis (.16 per 1,000 which he compared to an urban death rate from tuberculosis in Europe and America of 1.5-2.5 per 1,000) (ibid 1907:129-30).

This was a modest, specific argument that tuberculosis was not an imported problem that could be screened out at the border. Later, Bryce argued that American studies indicated that it was the urban conditions that immigrants faced that led to tuberculosis rather than any imported infection:

> Unfortunately, the studies made, whether of Jewish, Italian or Polish immigrants in the United States show in the great cities at least seventy-five per cent of these people were crowded, and that their declension in the matter of health and notably in the increase of tuberculosis is both rapid and fatal (ibid 1910:12).

Rather, Bryce advocated a careful case-by-case assessment of immigrants with tuberculosis, in which the criteria for admission should include the degree of illness, the financial circumstances and the family situation of the individuals involved (ibid 1908:123).

> How far the excluding clauses of the Act should be made operative in this sad but interesting class of cases by our medical officers at seaports, is a matter which has received very careful attention (ibid).

Exclusion from Canada was called for, "... if the immigrant is in an advanced stage of the disease, or is without funds..." A 'humanitarian standpoint' was in order, "...if he comes seeking health, advised by his physician, say in England, is not at an incurable stage, and has a reasonable amount of money or is coming to friends" (ibid).

It is not surprising that Bryce's hypothetical immigrant coming to seek a cure for tuberculosis should originate in England. These were not, however, the only tuberculosis cases who might be admitted:

> Other cases where a member of an otherwise good family is infected, where a wife or child is coming to a husband or father already settled in Canada, have to be dealt with separately and the course of action to be determined on with due regard to the best interests of the individual and of Canada (ibid).

This approach to tuberculosis, in a period in which the disease was taken very seriously and commonly linked to immigrants, is indicative of the general attitude towards physical disease displayed in Bryce's reports. A firm stance was taken against the view that many diseases were at root imported problems. Year after year, the reports noted the small number of cases of acute contagious or serious disease detected amongst immigrants to Canada (e.g. ibid 1909:108, 1907:129, 1906:127, 1905:134)

Tuberculosis and physical disabilities were seen as possible indicators of degeneracy. In these cases, Bryce argued for consideration of the 'personal equation', and particularly the family situation. In these circumstances, the immigration of a strong, self-sufficient working family far outweighed the potential for importing degeneration.

The individual medical inspector was to be given discretion to evaluate and act in these conditions. As Bryce (1908:406) noted with regard to the rejection of intoxicated immigrants, "It just depends on the opinion of the medical officer. The idea is, is that man going to be of use to Canada?"

This question was open with regard to conditions which might or might not be taken as indications of degeneracy. In contrast, this question was basically closed in the areas of pauperism,

criminality and mental handicap, which were absolute grounds for exclusion, except in situations where the rest of an accompanying family would be 'of use to Canada'[22]. The centrality of the family in these considerations reflects the new hygiene's emphasis on the regulation of home life, discussed in the next chapter.

3.3.3 The Rise of Civil Criteria

In the early twentieth century, public health played a central role in the transformation of the regulation of immigration as a feature of Canadian social policy. The basic criteria for the inspection of immigrants derived from public health policy founded on theories of race degeneration. It was public health officials who directed and conducted these inspections. Public health officials at all levels discussed immigration as a crucial factor in the resolution of social problems.

The generally broad conception of public health issues in this period was reflected in the theory and practice of medical inspection. This was true particularly in the second period of inspection when the search for indicators of degeneracy became a major focus. The healthy and desirable immigrant was one who would be of use to Canada, free of the taint of moral degeneracy, family-oriented and willing to work.

The line between medical and civil criteria for the rejection of immigrants was thin and permeable. In 1907, Bryce

argued that even the apparently non-medical cases detained or excluded involved a measure of medical judgement:

> The 159 detained as likely to become a public charge are very frequently medical cases, since their physical and mental ability is largely a determining factor...Criminals frequently come under the same category and often as physical and moral degenerates have developed the immoral traits which have placed them in the criminal class (ibid 1907:131).

In immigration controls, as in other areas, public health played a crucial role in defining and confronting new social problem areas. As elsewhere, the analysis and methods that public health brought to these new problem areas were ultimately found wanting and replaced combining the directly economic and narrowly medical. In the area of immigration control, this was reflected in the rise of civil criteria in the selection of immigrants.

Civil criteria first had a profound impact on the control of immigration through the designation of minimal amounts of money required by immigrants to enter the country. The proportion of immigrants rejected on this basis rose rapidly once this requirement was introduced, from seven per cent in 1907-08 to forty-seven per cent in 1910-11 and remaining a significant factor from then on (ibid 1919:18). This was an issue in which public health judgments were not required.

The deportation of immigrants after settlement in Canada was also increasingly on the basis of civil criteria. Most immigrants were deported for medical causes until 1907-08 and for civil causes thereafter (ibid). This change in policy was linked

to the economic depression of 1907-8 (Drystek 1982:417-8). Immigrants deported for civil causes included those charged with criminal acts or seeking public assistance. Bryce wrote regarding deportations, "Most of these are undesirable from the social rather than directly from the medical viewpoint" (Canada. Immigration 1918:27).

Later, political criteria would also become central in deportation (Roberts 1988b:78-80; Avery 1979:78-88). The Commissioner of Immigration reported in 1919, "Several revolutionists were arrested, some of whom were deported, interned or are still pending deportation" (Canada.Immigration 1919:27). This use of political criteria was evident in the public health literature as well.

Clarke (1919:443) directly linked immigration policy to unrest in Canada: "...undesirable immigration is one of the most potent causes of the disturbances." Degenerate immigrants brought with them dangerous doctrines:

> Bolshevism is not a new world disease, but merely a hot house product imported from the slum centres of Europe, where degeneracy has produced its inevitable results.

Medical inspection was not eliminated as the importance of civil criteria in the regulation of immigration rose. It changed in form as it moved from the inspection of disembarking immigrants to a prior check-up in the country of origin. The criteria became more narrowly medical as assessments of character, etc. were largely subsumed under directly economic and political considerations.

Roberts (1988a:30-31) wrote that after 1919, civil authorities increasingly dominated the selection of immigrants. The discretion of medical inspectors was dramatically reduced as "port doctors were subordinated to the civil agent". In this ultimate subordination to a combination of economic and narrowly medical policy, the history of medical inspection reflected the general pattern of development of Canadian public health.

3.3.4 Canadianisation: The Assimilation of Immigrants

The tasks for public health in the area of immigration did not end with the exclusion of dangerous or degenerate types at the border. Those immigrants who were admitted had to be assimilated into society, or Canadianised[23]. This process required the teaching of a whole range of skills and standards, revolving particularly around the family and the home.

The Canadianisation of immigrants was an important aspect of the regulation of working class life. A British public health official referred to this regulation as the "state standardisation of national life" (Pattin 1909:40). Standardisation in this sense had two aspects: the provision of a national standard of necessities of life and the establishment and enforcement of standards for work and home life. The assimilation of immigrants was a part of the process of standardisation in the second sense, the development of expected standards of behaviour for the whole national population.

The development of expected national standards of behaviour meant overcoming differences in certain areas. Many of these differences were regarded as products of ignorance, to be solved through education. Others were the result of class distinctions, to be solved through the generalisation of norms and patterns between classes (specifically from the middle to the working class)[24]. Still others derived from ethnic and cultural differences, to be solved through assimilation.

The Canadianisation of immigrants, then, was a specialised feature within this broad project of standardising the working class. It was theoretically rooted in environmentalist theories of race degeneration, which traced problems back to conditions and their moral consequences rather than biological roots. It was linked to an immigration policy which excluded immigrants tainted with degeneration while accepting those regarded as culturally backwards on the understanding that they could be elevated to the level of national standards through education.

> The notable absence of defectives amongst the peoples from southern countries is a matter of much interest and, contrary to a too popular opinion, it appears that if compulsory education can be generally enforced we have in such races not only an industrial asset of great value but also the assurance of a population remarkably free from the degenerative effects seen in those classes which have been for several generations factory operatives and dwellers in the congested centres of large industrial populations (Canada.Interior 1910:110, emph.added).

Not everyone was regarded as educable in this way. Medical inspections were used as part of an "informal exclusionary programme" directed against American blacks (Troper 1972:140).

Asians and blacks were generally regarded as unassimilable among Canadian immigration policy-makers (Avery 1979:7). Canadian immigration policy at the time was overtly racist, as indicated for example by the head tax imposed on Chinese immigrants. W.D. Scott (1911:113), the Superintendent of Immigration told a House of Commons Committee that the three categories to be excluded from Canada were the physically, mentally and morally unfit, those from unassimilable nationalities, and those likely to crowd into urban centres. He described the second category as:

> Those belonging to nationalities unlikely to assimilate, and who consequently prevent the building up of a united nation of people of similar customs and ideals.

Bryce vacillated on the question of the assimilation of blacks and Asians. On the one hand, he could describe Asian immigrants as "on the whole an inferior type of immigrant" on the basis of the high proportion detained in Vancouver for eye diseases (Canada.Interior 1907:126). On the other, he could write of Asian immigrants:

> Were these people, who have shown themselves on admission in most instances industrious and law-abiding, forced by municipal regulations to occupy better houses, and prevented from crowding into old and insanitary houses, for which landlords exact excessive rents, there seems to be no reason from the public health standpoint why they should not be allowed to enter where accepted as physically healthy (ibid 1906:119).

He could highlight the "remarkable fact" that 26 of 398 West Indian immigrants were deported. "Their ineffectiveness as citizens is measured when the deports stand to the total as 1 to 15" (ibid 1913:142). Yet he himself pointed out the material

basis for these deportations, as these were mainly domestic servants who were deported as public charges when jobless (ibid).

He could sound positively lyrical outlining his vision of a multiracial Canada that would be:

> ...more picturesque, since in it are intermingled the manners and customs of peoples developed separately in their ancient environment, each having elements of truth and beauty...and more precious, in the degree that it becomes more closely knit and fulfills the dreams of those who desire to see all races and tongues worshipping as one in a common Temple of Peace, and praying to the common father of all (ibid 1914:181).

In general, this duality in Bryce's thinking reflected general contradictions in the approach of Canadian public health officials to questions of race and nationality. There were officials such as Clarke (1919:444), who advocated an extremely exclusive immigration policy after World War I, favouring only rural British immigrants. However, in this as in his extreme eugenicism, Clarke was on the margins of public health opinion. In general, public health officials seemed to regard most immigrants as assimilable with the definite exception of those tainted with degeneracy and with the possible exception of blacks and Asians. Contradictory environmentalist and biological views of race contributed to the vacillation of officials between optimism regarding assimilation and racist typing.

The whole question of Canadianising immigrants was posed most directly by the correlation in urban centres between slum conditions and concentrations of immigrants. Public health officials explained this correlation in different ways. At one

extreme, Clarke (1915:463) wrote that many immigrants gravitate toward slum conditions:

> ...the majority deliberately seek the same kind of surroundings as those which they left in the Old World. Toronto can no longer boast that it is without slum centres...

At the other extreme, Shaver (1916:433) wrote of urban social problems:

> Strictly speaking, these problems do not originate with the immigrant. It is true that they are aggravated by the immigrant, but perhaps it is more true that they aggravated the immigrant.

Most public health officials fell between these two extremes of seeing immigrants on the one hand as deliberately seeking out slums and on the other as victims of slum conditions. This view is perhaps best summarized in the ironic statement by Plumptre (1914:27):

> ...the difficulties in connection with public health and housing are very largely due to the enormous influx of persons, some of whom are not accustomed to city life, and who, when transported from small villages and country districts in the older countries, find themselves incapable of using the facilities of city life, even if they had them.

Public health officials were not blind to the economic circumstances faced by immigrants (and others) trying to eke out a living in Canada's urban centres. They were aware that immigrants did not have many of 'the facilities of city life' due to dire economic circumstances. Some, such as Bryce (Canada.Interior 1906:119, also Roberts 1912:179-81) were critical of predatory landlords who profited from the vulnerable position of immigrants. Others clearly recognized that overcrowding was

produced by material necessity (e.g. Laurie 1913:455, Conservation of Life 1919:30-31).

At the same time, immigrants were portrayed as culturally backwards and poorly equipped to cope with urban conditions. Laurie (1913:455) described immigrants as "...the poor, the ignorant, the superstitious, the downtrodden..." and "...mostly ignorant and careless of the first principles of sanitary protection." These tendencies were compounded by cultural practices such as "...drunkenness, carousing, marriage feasts and stabbing affrays" (Roberts 1912:179).

The solution, then, was twofold. The dire economic conditions required intervention, particularly though the regulation of landlords (e.g.ibid:181). At the same time, a programme of 'moral elevation' was required. Bryce(1913:646) wrote that the immigrant "...will either become a lowering element in the ethical status of our people or else he must be raised to ours."

While there was considerable discussion about the relative priorities of material improvement as opposed to the education of immigrants, there was a general consensus among public health officials that both were required. The emphasis within the parameters of official public health work was on education, though many officials used their position to advocate modest material reforms.

The key to elevating the immigrant was to increase the contact between Canadians and newcomers. Public health officials tended to be critical of those Canadians who simply looked down

on immigrants. Shaver (1916:434) was critical of the "...almost universal assumption that we are the chosen people of god and all others are of an inferior race."

Bryce (1913:646) argued that it was the responsibility of local public health officials to "...point out the duty of the individual citizen to the immigrant who comes to Canada because his services are required." This duty consisted largely of basic day to day contact which would serve to assimilate the newcomer into the community. Bryce wrote:

> ...we may fairly hope that as the immigrant becomes more recognized as a factor in the social problems of our communities, so will our people more and more develop methods whereby he will no longer be looked upon as a stranger within our gates, but as a strand to be woven into the social fabric (Canada Interior 1914:161).

Shaver (1916:433) wrote that the immigrant to Canada was treated "as merely a commercial asset", receiving low pay and very little patience or understanding in adjusting to the English language[25]". Plumptre (1914:27-8) compared the Canadian handling of immigrants to the mistreatment of invited houseguests. Hodgetts (1912:544) complained that due to official inactivity Canadians were "...permitting a foreign element to live in worse conditions than would be permitted in their own country."

If Canadians expected more of immigrants, it was necessary to offer more. This attitude was captured in the final stanza of an unsigned poem on immigrants printed in Public Health Journal

(1913:674-5) entitled 'Strangers Within Our Gates':

> Oh, these builders of the nation!
> They need us and we need them,
> We can make them high in station,
> We can make them gentlemen,
> We can give them homes beside us,
> In our vast dominion's wild,
> As they give their strength to help us,
> Neighbours, we'll be reconciled.

Clearly, this view cut against the anti-immigrant prejudices that were common at the time (e.g. Avery 1979:41). Instead, public health officials emphasized the obligation to immigrants, the mutuality of benefit and the need for reconciliation. This required an active intervention which could both overcome the prejudices of Canadians and contribute to elevating immigrants.

The locus of this intervention would be the home. Laurie (1913:455) wrote of immigrants:

> The duty falls upon the people of Canada to help these people to become good citizens, to teach them that their prosperity and happiness depends to a large extent upon the care they take of their homes and surroundings.

Public health officials did not stop at advocating that Canadians teach immigrants citizenship. Through local health departments they actively promoted what Roberts (1912:182) referred to as "...the education and enlightenment of the heterogenous mass which forms...the substratum of society." This was undertaken particularly through visiting public health nurses and other health visitors[26].

These health visiting programmes were aimed at all working class people, whether Canadian-born or immigrant. However, special efforts were made to reach immigrant communities. In

Toronto, two nurses fluent in languages other than English were hired (Brittain 1915:370)[27]. As well, infant welfare material was translated into Italian and Yiddish (Royce 1983:65). In Port Arthur, public health materials were printed in the Finnish papers (Laurie 1913:456).

Language, however, was not the only barrier faced by these health visitors. Cultural traditions often made parents resistant to new 'scientific' child-rearing practices in such areas as clothing and feeding (e.g. Royce 1983:65, Laurie 1913:456). As well, immigrants often viewed health officials as alien intruders:

> ... they look upon health officials as their natural enemies, whose aim and desire is to interfere and make life unpleasant for them (Laurie 1913:455, see also Lewis 1982:140, Royce 1983:65).

This resistance to public health officials was not limited to immigrants. It took an organized form in opposition to compulsory vaccination (Bator 1983, Andrews 1979:191). It was a particular factor in relations with immigrant communities. It is perhaps not surprising given the attitude of these officials:

> Very few of the foreigners believe in fresh air, they keep their windows closed and their rooms are close and foul-some times so bad that I had to turn back until the window was opened (Laurie 1913:455).

This cringe at the doorway, turning back because of sights, smells or sounds, was likely to be reproduced in thousands of cases. Such an attitude was not the basis for a trusting, open and mutual relationship. It was perhaps summarised in Hodgetts' (1913:448) statement "...we have not gone down to the people and

striven by every means to raise them..." At best, going down to the people expresses condescension; at worst, contempt.

Shaver (1916:435) pointed out that it was important to teach immigrants, but also to learn from them and be sensitive to them. But given the basic didactic agenda of public health, learning from immigrants was bound to be subordinated to teaching things to them. For example, Shaver himself saw the basis for political corruption in the fact that the 'adult foreigner' was given the franchise, "...with absolutely no provision made for his education into what citizenship means" (ibid:434). In short, the judgement of immigrants was suspect without substantial education.

This didactic agenda left public health officials rather ambivalent about the formation of ethnic communities in Canada. On the one hand, they could admire the capacity for self-help that such communities demonstrated (e.g. Bryce in Canada.Interior 1907:135 and 1914:180). On the other hand they expressed concern that concentrations of immigrants might not only protect alien habits, but also adversely influence surrounding communities (Bryce 1913:642, 1912:688 and in Canada.Interior 1910:12). Urban concentrations were seen as particularly problematic (Bryce 1912:688).

In short, relations with non-anglophone adult immigrants posed certain difficulties. One of the ways around these problems was a strong orientation to immigrants' children, part of an

overall orientation to children. Roberts (1912:182) wrote, "Our chiefest concern is with the children, the rising generation."

Children were regarded as more susceptible to new influences and less bound to old ways:

> It is easier to influence the open mind of a growing individual to recognize the defects of old habits and methods and to carry out what reason tells them is a right an acceptable mode of action, than it is to persuade the adult, hardened by custom (Adami 1912:372-4).

This orientation was largely aimed at shaping the children themselves into healthy and moral citizens. It also aimed to use the children themselves as agents carrying new standards and habits into their parents' home. Laurie (1913:456) wrote that the best way to remove difficulties in dealing with immigrants was "...by educating the coming generation, who will help spread this knowledge in their homes[28]."

In this, as in other areas, the assimilation of immigrants was part of a larger intervention into the working class family by public health officials. Certain programmes were geared to the particular problems posed by immigrants in this project of social improvement, especially in the areas of language and cultural tradition. Generally, the Canadianization of immigrants and the elevation of workers born in Canada were part of the same agenda, the state standardization of working class life.

Public health officials, then, were optimistic regarding the possibilities of assimilating new immigrants. They actively promoted this assimilation through health visiting programmes and education aimed at schoolchildren. This project of

Canadianisation was one feature in the broad programme of standardisation, the establishment and enforcement of standards governing home and work life. These standards were to be internalised and enforced through self-discipline, reinforced by various forms of state supervision.

CHAPTER FOUR
PUBLIC HEALTH AND THE REGULATION OF THE FAMILY

Public health in the early twentieth century was engaged in a project of nation-building. This project had two dimensions. The first of these was the delimitation of a national working class, discussed in the previous chapter. This involved not only the use of immigration controls to establish boundaries around the working class belonging to a particular state, but also the definition of that class in terms of nationality as understood through particular racial and cultural typologies.

The second dimension of that process, to be discussed in this chapter, involved the regulation of the social reproduction of that delimited class. In the earlier sanitarian period of public health, this regulation had concentrated on eliminating 'physical barriers' to working class improvement in the form of dismal and disease-ridden urban environments. In the era of the new hygiene beginning around the turn of the century, this regulation focussed on the domestic environment, the site of self-reproduction through the family system. The key to the improvement of the domestic environment was the 'standardisation[1]' of domestic labour, the private labour process of self-reproduction performed primarily by women.

This focus on women's domestic labour began to develop in local public health activity in certain British municipalities during the 1890's. The Lady Mayoress of Liverpool clearly outlined this domestic orientation in her address to the 1894 Conference of Ladies on Domestic Hygiene:

> It has been truly said : 'Architects may build houses which in point of structure shall be very temples of Hygeia, but woman will ever make them nurseries of disease and death so long as she ignorantly violates household sanitary law:' and yet in spite of the accuracy of such a statement how little is done, or rather how much more is needed to be done, in order to train girls to a right estimate of the value of those sanitary laws, and to give them an opportunity to acquire that intelligent knowledge of hygiene and sanitation which is so absolutely essential to the physical and moral welfare of both individuals and communities (Bowring 1894:413).

This domestic orientation moved to the centre of public health activity during the period 1900-20. The spread of key social diseases such as tuberculosis, infant mortality and sexually transmitted diseases was defined primarily as a product of ignorance. This ignorance was understood in terms of theories of race degeneration as the product of moral decline under conditions of urban industrialism. The aim was to reverse this decline, to remoralise the family beginning with its most important members, the women seen as home-makers.

Women were seen as playing a privileged role in this process, both as reformer and as reformed. Public health was linked strategically to a broad social reform movement which included such participants as the temperance movement, the settlement houses and pioneer social workers, moral purity groups, the child rescue movement and the women's suffrage movement. The empowerment of women was part of the social reform agenda, though this was linked strictly to strengthening women's traditional role in the existing division of labour[2].

Early twentieth century public health saw the regulation of women's domestic labour as the cutting edge in the moral and

physical regeneration of the working class. This regulation was to be accomplished primarily through social work methods, involving a combination of education (through pamphlets, schools, exhibits and visits), supervision (through regimes of home visiting) and direct provision (of particular requirements of life under specific circumstances). This approach to the working class question put public health at the forefront of social policy in this period.

This approach would give way to new forms of economic and medical regulation which took full form in the post-World War 2 welfare state. Public health in the era of the new hygiene was based on the conception of social problems as the product of environmentally-induced moral decline. This conception would be replaced by one which centred on specific economic (specific inadequacies of the wage system in providing for family life, e.g. during periods of illness or unemployment) and medical (access to treatment for definite diseases) issues.

With the development of the welfare state, the definition of problems in primarily moral terms and social work methods of intervention would be reserved primarily for those residual 'hard cases' who continued to pose problems despite benefits and health care (see J.Clarke 1980:75,80). The regulation of women's domestic labour through education, supervision and direct provision continued to play a role in social policy, though a secondary one. This section will examine a framework which

played a crucial role in a transitional moment in public health, before being displaced, fragmented and marginalised.

4.1 A Scientific Morality of the Family

A. Diseases of Ignorance

Public health in the era of the new hygiene identified ignorance as the central factor in the spread of such health problems as tuberculosis, infant mortality and sexually transmitted diseases. This ignorance was understood not only as the absence of knowledge, but also as a moral problem connected to the decline of character induced by urban industrial conditions. New germ theories of disease also played a part in this conception of ignorance, as the elimination of germs was the object of scientific hygiene. Disease was identified with ignorance on the basis of an articulation of social (race degeneration theories, statistical methods) and medical (germ theory) science.

Tuberculosis, for example, had traditionally been regarded as a hereditary and essentially untreatable disease. The discovery of the tubercle bacillus (the causative organism of tuberculosis) by Koch in 1882 opened up the possibility of a new approach. However, no preventive method followed immediately from this discovery (Frazer 1950:259).

The preventive method which did develop resulted from the articulation of bacteriology and sociology. While bacteriology isolated the contagion, statistical methods identified the

conditions under which it spread. As Koch himself told the 1901 International Congress on Tuberculosis in London, "... it is the overcrowded dwellings of the poor that we have to regard as the real breeding place of tuberculosis" (cited in Ont.PBH 1901:88).

Yet there was little public health officials could do to address the problem of overcrowding as such. This is illustrated by this statement from a report on the 1899 Sanitary Institute Conference in Britain:

> Dr. Newsholme considered that overcrowding is the central problem in public health. It was one which surpassed our present ability to solve (Public Health Editors 1899:26)[3].

Newsholme went on to call for a concentration of effort in the campaign to prevent tuberculosis. Rather than aiming broadly to eliminate overcrowding, public health officials should aim specifically at the immediate environment of infected persons. Notification of those suffering from tuberculosis would permit such concentration:

> Knowing the cases of phthisis[4], we could take intelligent precautions against its spread in overcrowded houses; while ignorant of them, we were spending and exhausting our energies on overcrowded houses of much less importance, from the standpoint of the spread of disease (ibid).

The need to concentrate efforts meshed with an alternative explanation of the connection between poverty and tuberculosis. The incidence of tuberculosis could be statistically correlated to poverty and overcrowding, but that did not mean that these were the causal variables. As Newsholme wrote in an annual report:

> Tuberculosis has been described as a <u>disease of misery</u>. This is true, in the main, because misery favours infection;

> to a lesser degree because it renders the patient a ready victim to infection. But tuberculosis is much more a disease of ignorance, and many of the measures for its treatment and relief - whether by home visits, dispensaries or sanatoriums - if properly employed, have among their most valuable results the hygienic training of the patient (U.K. LGB 1909:233-4, emph.orig.).

Sociology passed by way of bacteriology to generate this particular theory of ignorance. From this theoretical perspective, overcrowding became more a question of domestic arrangements and standards than one of objective material conditions. Gardiner (1904:887), for example, argued that the woman as manager of the house had a crucial role to play in the fight against tuberculosis:

> We have seen that the lack of fresh air, of sunshine, of cleanliness, of proper food and clothing; and overcrowding (in the bed-room, sitting-room, etc.) are all important in the causation of consumption, and is it not perfectly evident that every one of these items lies well within the woman's province, and that it is in her power to remove them?

Overcrowding in the sense of too many inhabitants crammed into too little space due to sheer poverty was not within woman's province to improve, but the furniture in the bed and sitting rooms could be better arranged. Ignorance, particularly in the area of domestic hygiene, was identified as the key factor in the spread of tuberculosis which was subject to change through public health intervention. The problem of poverty as such was less important than the lack of knowledge and demoralisation of the poor.

A similar perspective was applied to the spread of infant

mortality and venereal diseases. Infant mortality, like tuberculosis, was correlated to poverty:

> ...this waste of infant life is a class mortality; it is practically confined to artisans and the labouring classes, and does not exist to any serious extent in the upper and middle classes (Carpenter 1906:129).

Again, however, poverty in itself was not seen as the causal factor. Newsholme wrote that if poverty itself were the factor, "...the death rate in Ireland and still more so in Norway should be much higher than in England and Wales" (UK.LGB 1910b:55). Yet it was not. The differential mortality by class must be explained in another way.

> The difference in the main is due to certain removable evils, which are commonly associated with poverty in this country, and from which the well-to-do in a large measure escape (ibid)[5].

These removable evils generally included bottle feeding, maternal neglect and the employment of mothers. These factors, with the partial exception of the third, were seen as products of ignorance to be remedied through education. The MOH of Huddersfield wrote of the measures taken against infant mortality:

> Education is the most important. It may not be doubted that in the vast majority of instances where babies die under the care of their parents, nothing but sheer lack of information as to the proper method of dealing with baby permits harm to accrue (Moore 1906:21).

There is some variation in the literature in the degree to which the poor parenting of working class mothers was ascribed to wilful neglect as opposed to naive ignorance or demoralisation due to environmental factors. Some sources leaned very heavily

towards blaming working class women for their supposed irresponsibility and lack of commitment.

The Interdepartmental Committee on Physical Deterioration (1904:40) reported that witnesses had stated that: "...a large proportion of British housewives are tainted with incurable laziness and distaste for the obligations of domestic life... " Further, "...there is no lack of evidence of increasing carelessness and deficient sense of responsibility among the younger women of the present day" (ibid:55). Similar complaints regarding 'laziness', 'neglect' and 'lack of parental control' can be found elsewhere[6].

Newsholme (UK.LGB 1910b:73), on the other hand, specifically refuted the claim of the ICPD that irresponsibility was rising among young women. He and others ascribed wilful neglect to only a small minority of bad mothers on the margins of the working class. Instead of neglect, bad mothering was attributed to demoralising circumstances, bad habits, and the lack of real information.

> Now 'bad motherhood' is seldom wilful. It is generally due either to ignorance or to inability to cope with the circumstances of life, but the ignorance of many of the lower-class mothers is so appalling that it looks like wilful blindness, and certainly tends to produce a fatalism that amounts to callousness (Gaffikin 1908:220).

Mothers with the best of intentions were essentially murdering their infants because they didn't know any better:

> It is one of the most pathetic things conceivable - the mother, overflowing with love of her offspring, maltreating it and causing its death through sheer ignorance (Moore 1906:21).

Ignorance, then, was the key area of work for public health against infant mortality. Ignorance was similarly seen as a factor in the spread of venereal diseases.

> The evils which lead to the spread of venereal disease are, in great part, due to want of control, ignorance, and inexperience, and the importance of wisely conceived educational measures can hardly be exaggerated (UK.RCVD 1916:60).

Ignorance in the area of venereal disease meant many different things. Among the medical profession, it meant a need for improved education regarding venereal diseases and their treatment (ibid 59). Among the population at large it meant either the presence of the wrong information or a naive lack of knowledge. The RCVD suggested that the former was a problem among the poor; the latter among the better off.

> In over-crowded districts very young children acquire much precious information on sexual subjects in the most undesirable way. In better conditions, children grow up in ignorance of such matters, and this ignorance is carefully and often unwisely fostered by their parents (ibid:60).

The most significant social diseases in this period, then, were seen as products of the impact of ignorance upon the domestic environment. The solution to this ignorance was education, particularly in the home, combined with such modest material improvements as were possible. The key was the emphasis on what Newsholme called 'the personal factor' (UK.LGB 1913b:69).

Systematic attention to the knowledge, skills and habits of individuals was the key to breaking the cycle of ignorance, material poverty and demoralisation[7].

B. Ignorance, Morality and Science

Early twentieth century public health officials in Britain and Canada saw moral regeneration as the key point at which to break the cycle of ignorance, poverty and demoralisation. This project of moral elevation did not exclude but in fact required material assistance and practical instruction. But neither of these would be effective if the problem of decline in moral character was not confronted.

This project of moral elevation was neither new nor unique to public health. It had been central to many religious groups in Britain through much of the nineteenth century. Public health was distinguished from these earlier religious approaches in that it claimed a scientific basis for moral regeneration.

Public health officials saw themselves as theorists and practitioners of an objective science of social improvement. This science aimed to improve physical, mental and moral health through promoting standards of conduct for family life. These standards ranged from the basic rules of domestic hygiene to the correct methods of child rearing, from etiquette to sexual propriety.

Just as science had assisted in the conquest of external nature, so could it contribute to the control of humanity's own nature:

> As man has learned to subdue Nature, to discover her secrets and make them serve his needs, so must he struggle to overcome in the mental and moral sphere until discipline shall make conformity to high ethical ideals the law and normal routine of his life. (Bryce 1914:222)

In all this, the relation of science to morality was a complex one. There was no doubt that public health aimed to touch the soul as well as the body of its clientele. Hamilton (1918:62) wrote that it was necessary in venereal disease work, "...that while we cure the bodies we must also recognize the souls of those who have gone astray..."

However, this touching of souls was not to be accomplished through moralising in the traditional sense of preaching and admonishment. Smythe (1918:68) wrote that public health was only concerned with the moral side of the venereal disease question, "...in so far as scientific and practical treatment of the subject shall be found to be the foundation of moral principles."

This scientifically-based morality could be more effective at changing behaviour than traditional methods:

> The dread of the disease and fear of its fell and deadly consequences would provide a greater deterrent from vice than much moral admonition, unsupported by science (ibid:72).

Rather than preaching, public health was attacking ignorance. The major obstacle in work against sexually transmitted diseases, for example, was ignorance. Smythe (1918:68) wrote, "Ignorance, more than any other cause, has led to the ravages of these terrible diseases."

Ignorance meant more than mere lack of information. An ethical dimension was generally present. This was particularly

true in the area of sexuality. Newsholme (1925:238) described the aim of anti-venereal disease work: "This is no less than the creation of a higher general conception of sexual morality than is generally held."

In this work, public health staked a claim to some of the turf previously occupied by moralising agencies:

> The character of most of this work falls directly under the purview of what is known as sanitary science or hygiene, but up to the present this fact has not been fully realized or, if it has, it has been lost sight of because of its being hailed as work for the improvement of the morals of the people. (Hodgetts 1914:449)

This did not mean that scientific hygiene was seen as a complete substitute for traditional moral agencies such as religion. In fact, a division of labour was envisaged in the project of moral elevation. Smythe (1918:69-70) included the following as suitable sex education instructors, in order of priority: parents, the church, the press, general propaganda.

Parents were regarded as the primary source of moral guidance (Bates 1918a:57). The moral autonomy of the home centred on the authority of the parents in areas of conscience among others. However, these educators themselves needed educating. The instruction of parents was regarded as a particularly high priority (Balliet 1913:684, Smythe 1918:69).

The second important source was the church and church-related institutions (such as the YMCA and YWCA). Smythe (1918:69) wrote: "Failing the agency of parents, the next obvious channel is the church..." While the attitudes of individual public health officials ranged from deep religious conviction to

scientific humanism, they generally tended to see scientific morality as a complement to, rather than substitute for, traditional religious institutions.

This complementary relationship with traditional religious institutions was required as the public health regime of scientific morality was necessarily limited. A similar division of labour existed between public health and the voluntary sector. Public health, as an aspect of state regulation, had to carefully navigate the boundaries between public and private related to the moral autonomy of the family.

A Public Health Journal Editorial (1912:198) warned of the importance of respecting the autonomy of the family:

> Professors of eugenics for instance are doing good by calling attention to the question of preventing marriage among the degenerate and manifestly unfit, but to preach too much regulation and interference is to cause mischief and harm.

The editorial remarked on the value of considering eugenic factors in certain areas of marriage, sexuality and reproduction. However, it added: "Let us not forget moral beauty, character, intellect, human worth and nobility" (ibid). The family was more than a union for biological reproduction, it was a method of social reproduction. This social reproduction was best achieved when the family operated by conviction, not just coercion.

This meant respecting the moral autonomy of the family, particularly in regard to such considerations as romance. Balliet (1913:366) wrote of the importance of having children in school read the best literature of romantic love:

> This is one of the most effective means of spiritualizing the sex instinct and of inspiring the pupil with lofty ideals as to the sex relation.

The aim of the scientific morality of public health was to instill disciplined standards which would create appropriate behaviour primarily by conviction, backed up by various forms of inspection and coercion. The internalisation of standards enforced by self-discipline could only be achieved through regulatory techniques which recognised the private realm of the family as one involving a degree of moral choice. The status of public health as a science was absolutely crucial in rationalising the regulation of this private moral realm, but even so it did not resolve all problems.

C. Morality, Sexual Hygiene and the Scientific Family

The private realm of the moral autonomy of the family is constituted in such a way as to narrowly restrict the range of moral choices. One of the crucial ways in which the scientific morality of the family worked was through defining limited bounds of acceptable family behaviour within which a degree of choice could be accommodated. One of the ways this was done was through the regulation of sexuality.

The regulation of sexuality has been one of the foundations of the family system. The state regulation of sexuality increased substantially in the later nineteenth century, with legislation regarding prostitution, homosexuality, marriage and divorce (Weeks 1977:3-20). This regulation operated not only through legal sanction, but also through a process of moral formation.

Public health contributed to the regulation of sexuality. It offered a scientific and rational basis for limiting sexuality to properly constituted, medically sound, duly married monogamous heterosexual couples. As elsewhere, the primary focus of public health work was on hygiene education, in this case instruction on sexual hygiene.

Sexual hygiene was more than a scientific approach to disease prevention. Certainly, the prevention of venereal diseases (during and after World War I) was a major objective of sexual hygiene. But sexual hygiene was also linked to eugenic theories of good breeding, general moral elevation, and specific

concerns about sexuality and the mentally handicapped. Underlying all of these considerations was the buttressing of the family system.

In the period 1900-20, the theory of sexual hygiene tended take a broader form in Canada than in Britain, based on sweeping generalisations regarding environment and eugenics. Such generalisations were not absent in Britain, but were being replaced in this period by a more narrowly medical approach. This shift in Britain towards a more narrowly medical approach stressing treatment was the mark at the level of sexual regulation of the overall shift from social and moral to economic and medical regulation.

Sexual hygiene was seen as one aspect of an all-round programme attacking an interrelated set of social problems. Venereal diseases were explained in broad social terms.

> [The Committee[8]]...is not unmindful of the underlying causes of venereal diseases going very deep down in social life, which causes involve such questions as low wages, bad housing, loneliness, lack of wholesome amusement, lack of affection and ordinary home pleasures, absence of an absorbing interest (what Donald Harkey calls 'the zest of the quest'), the isolation due to our present system of domestic service, and other kindred difficulties (Hamilton 1918:62).

The demoralisation of the working class, produced by material conditions, ignorance and vice, resulted in a cycle of problems including alcoholism, poor child rearing, mental illnesses and dangerous sexual behavior. Sexual hygiene was to be part of an overall campaign of moral regeneration.

1. Sexual Regulation in Canada

Public health officials in Canada linked the need for a new sexual hygiene to broad theories of moral degeneration. According to this view, the chief obstacle in the way of the creation of a higher sexual morality was the general demoralisation of the working class which impaired the development of mental, moral and physical discipline. Two specific conditions, seen as arising from this general demoralisation, were particularly threatening to sexual order: mental handicap and alcoholism.

Venereal disease, for example, was linked to mental handicap through prostitution. Clarke (1917:156) wrote that 75 per cent of all venereal disease was traceable to prostitutes, of whom 60 per cent were 'feeble minded'. 'Mental deficiency' was seen as creating impenetrable moral incapacity.

> The majority of immoral and diseased girls found in institutions are feebleminded, incapable of reform and self-support, and not desirable or safe members of a community (Keys 1918:99).

This moral incapacity was understood as a lack of restraint. Downey (1913:126) wrote, "The remarkable fertility of the mentally defective and their predisposition to sexual passions are generally recognized." The perception that mentally handicapped people were incapable of developing sexual discipline was one of the reasons given to justify institutional incarceration[9].

Similarly, alcoholism was linked to venereal diseases. Bates (1918a:57) wrote, "We have statistics for instance which I

think prove that the elimination of alcohol means the cutting down of venereal disease incidence.

Alcoholism was viewed as both a failure of restraint and an impairment of restraint. It was therefore, like mental disorders, linked to an inability to develop sexual discipline. The key to the regulation of sexuality through public health methods was the internalisation of sexual discipline. This discipline was the basis of a 'higher sexual morality' founded on science rather than religion.

> What we want is an educational campaign that will develop a better and nobler race of men, who will be masters of their passions instead of their servants as in many cases they now are (Hastings 1914:213).

This new morality would be particularly important for women. "Then and only then will man place woman back on the pedestal from which he has dragged her down" (ibid). The protection of women would be a feature of this new disciplined sexuality.

> If we are, as we believe we are, destined to become a great people, we must protect our girlhood and young womanhood. They are amongst the best assets of this glorious country (Cummings 1914:220-1, see also Ont. RCVD&FM 1919:22).

A very important feature of this new disciplined sexuality would be the control of biological reproduction along eugenic lines. This was to be done primarily through the promotion of sound and responsible (autonomous) choices rather than through coercive state control. People would be taught to breed well by conviction, to make informed genetic choices in marriage and reproduction. Balliet (1913:665-6), for example, recommended

that sex education begin with a eugenic agenda focussed on plants.

> It is not difficult to impress upon even young pupils where there is a school garden, the necessity of selecting the best seeds for planting and thus inculcate in a practical way a fundamental fact in heredity which may later be given its moral implications in a higher sphere.

The major exception to this educational approach to the problems of eugenics regarded the sexual regulation of the mentally handicapped. It seems to have been universally accepted among public health officials that mentally handicapped people should be sexually regulated on eugenic grounds.

The eugenic control of mentally handicapped people in this period meant primarily sexual regulation through segregation. This segregation was essentially to prevent reproduction through prohibiting sexual activity[10].

> ... the only safe place for the mental defective is in a training school or custodial institution, and that while they are there and under proper discipline, the danger from any increase in population from within is kept to a minimum (Downey 1913:126, see also Shortt 1912:307-8).

In this period, opinion in Canadian public health seems to have favored segregation over sterilization as the method for sexually regulating people who were mentally handicapped (e.g. Downey 1913:126). In the 1920's, some jurisdictions went further, adding sterilisation to programmes of segregation (e.g. Chapman 1977:15 re:Alberta). Whatever the method, early twentieth century public health favored the coercive restriction of the sexuality of people who were mentally handicapped on eugenic grounds.

Sexual regulation, then, fit generally into the scientific morality of public health. The negotiation of public and private realms was a crucial aspect in this regulation, leading officials most often in the direction of favouring internalised standards. Mentally handicapped people were excluded from this approach in that their 'ignorance' (in the double sense of lack of knowledge and lack of moral restraint) had a biological rather than environmental base.

This general orientation towards sexual regulation sharpened greatly during the World War I venereal diseases scare. This period saw a massive campaign launched to treat and, more importantly, to prevent venereal diseases. This campaign did not come out of nowhere. The Canadian medical literature included an increasing amount of material on sexually transmitted diseases in the early twentieth century, peaking just before World War I (Casselman 1981:106-7).

The context for the World War I campaigns was the discovery of significant numbers of venereal disease cases among military recruits. Fairly quickly, initiatives were launched within the armed forces. However, this was not regarded as sufficient as the major source of infection was seen to lie outside the army (Fitzgerald 1918:49-50, Hastings 1918:73). Therefore, campaigns to prevent and treat venereal diseases were launched among the civilian as well as military populations.

These campaigns were justified on the grounds of providing healthy people to fight the war and/or work in the factories:

> The first essential in the army is to have a good fighting machine. This means a maximum of available manpower and a minimum of waste. In other words, every man must be kept in as good physical shape as possible and as many physically fit men as possible kept in the ranks (Bates 1918a:53).

This meant not only action in the armed forces but also among civilians.

> the source from which soldiers receive their infection- whether before or after entering the army - is invariably a member of the civilian population of the country...no plan which we might evolve for the control of the situation would be complete unless we made some effort to control the source of infection (ibid:55).

Parallel to the need to combat venereal diseases to keep soldiers in shape was the need to improve productivity through keeping workers healthy. Private sector employers could be counted on to support venereal disease education to meet their own need for labour.

> Employers know it to be profitable to have healthy workers, and usually give sufficient time for the purpose at the expense of the firm (Struthers 1918:70).

The anti-venereal diseases campaigns in this period had three aspects: general education, treatment of those infected, and prophylaxis (the preventive treatment of those who "insist on exposing themselves to venereal infection" (Bates 1918a:53-4)). Of these, education for prevention was the first priority. The major message of this education was to limit sexuality to marriage.

> I may say that every effort is made to teach soldiers that absolute continence before marriage is the only preventive of venereal disease, and that every effort is made to discourage immorality (Bates 1918b:356).

Educational campaigns were launched among the military and civilian populations, working through a range of approaches to drive home the message that violations of sexual morality were threatening to the health (Smythe 1918:72). However, the message of these campaigns was not only negative.

One of the objectives of the venereal disease campaign was to develop alternative social habits to replace those associated with indiscipline, cheapness and ultimately, disease. These alternatives varied from good reading matter and normal recreation in the army to model boarding houses for employed women which provided a focus for structured socializing (Bates 1918b:358).

> The dance hall has been found to be a focus of immorality and infection. Why should mixed dances not be permitted in our schools or even in our parish houses or church halls in the evening - properly organized and supervised of course (Bates 1918b:359).

The venereal disease campaigns attempted to regulate sexuality through education which served both to scare people away from sex outside of marriage (marshalling scientific evidence) and to present some sort of conception of healthy social life. The former was clearly primary. Smythe (1918:70) wrote of touring exhibits organized for men, "...the knowledge imparted is found to be a deterrent from vice of the strongest kind."

This campaign of education had to overcome a legacy of silence surrounding venereal diseases, a particular dimension of ignorance in this area of work.

> In order to understand the problem of controlling venereal disease it must be remembered that owing to its very nature it has heretofore been regarded as something to be mentioned with bated breath, disgraceful to the individual and nauseating to the public (Ont.RCVDAFM 1918:3).

Prominent in the promotion of this regime of silence were parents who sought to keep their children ignorant about sexuality.

> Many parents wrap themselves in the fond delusion that their boy or girl knows nothing of the subject and that their child is as innocent of such knowledge as a babe (Struthers 1914:75).

Sexuality could not be regulated through silence because genuine ignorance did not exist. Children who did not learn sexuality from proper sources learned from "impure sources" and got a "false, distorted or vicious explanation of sex matters" (Balliet 1913:685, Struthers 1914:75). Even if ignorance were possible, it would not be sufficient.

> Even if it were possible to preserve children in absolute ignorance of sex facts until they were of age, this very policy leaves them prey of loathsome vices...There are but two paths, one of danger, and one of comparative safety. The path of ignorance is the path of danger (Smythe 1918:69).

It was simply false to associate knowledge in sexual matters with the creation of desire.

> It cannot be too strongly insisted upon that knowledge in itself does not beget prurience. The naturally prurient will find the material they seek even in the Bible (ibid:70).

Regulation, then, was achieved by providing solid, scientific knowledge of sexuality to replace the folk knowledge that had spread through the regime of silence. This was to

include even a sexual vocabulary separated from traditional, somewhat dirty, folk language.

> The terminology of science is the only terminology that is free from indelicate associations, and the very first condition of success in sex discussions, either with young people or with adults, is to give them a vocabulary free from these associations (Balliet 1913:686).

Public health aimed to effect broad changes in internalised sexual standards in order to eliminate venereal diseases. Officials aimed for a full-fledged 'battle against vice', "...the real contest that will tax the courage, the self-denial, the faith and the resources of humanity to their utmost" (Hastings 1914:217). This educational battle was not, however, the only front on which venereal diseases were to be engaged. Accessible medical treatment was an important complement to education, offering a more practical and immediate response to the spread of these diseases.

Treatment came to play an increasingly central role in the campaign against venereal diseases in Canada. The recognition of the importance of accessible treatment was present in the literature before World War 1 (e.g. Hastings 1914:214-16, Clarkson 1913:684). The emphasis on treatment increased as the shift towards economic and medical social policy began in embryonic form in Canada.

Treatment was to be offered in such a way as to minimise

stigma, so that sufferers were not forced underground.

> The providing of such facilities for treatment and advice as will enable those concerned to accept and use the remedies without being subjected to unnecessary publicity, or being regarded as objects of pity or scorn, is essential (Ont.RCVDsFM 1918:4).

This elimination of stigma, as will be discussed below, was somewhat contradictory in that it eliminated what had been considered a moral cost of sexual transgression. In fact, the shift towards treatment in the area of venereal diseases marked an important step in the separation of social and moral from economic and medical social policy. This shift in method was only just beginning in Canada, and was slightly more advanced in Britain. Sweeping moral regeneration was replaced by partial campaigns with specific objectives. The regulation of sexuality continued, but it took a more fragmented and technical form.

One important indicator of this shift in progress can be found in the history of an Ontario Royal Commission appointed in 1917. The initial mandate of the Commission was shaped by broad moral theories, calling for the investigation of both venereal disease and mental handicap, as these were regarded as theoretically linked (ibid 1919b:3). Yet the Commission ultimately reported separately on the two issues. Further, these reports emphasized treatment over broad moral reform. The moral orientation of public health theory and practice, explicit in the period of moral regeneration, became implicit in the era of medical and economic regulation. The scientific morality of the

family continued to figure prominently in public health theories, but in a new and more understated way.

ii. Sexual Regulation in Britain

The shift towards treatment in the campaign against sexually transmitted diseases linked to the reorientation of social policy began earlier in Britain than in Canada. This is not to say that there was not a moral side to the early twentieth century campaign of sexual regulation in Britain. On the contrary, moral themes were everpresent. For example, one article in a public health journal called for the use of the 'sanitary method' to prevent venereal disease. This sanitation, however, involved moral rather then physical cleansing.

> The moral atmosphere must be cleansed by a more vigorous suppression of certain nuisances - brothels, demoralising exhibitions, obscene literature, and public solicitation by men and women...In the same way removal of refuse must surely mean the removal from the centres of population of the feeble-minded, the morally defective, the unemployable-pitiful 'refuse' indeed (Wilson 1911:343).

Prominent officials such as Newsholme continued to raise the old moral themes.

> Alcoholism and venereal disease are the chief examples of disease caused by directly anti-social conduct; and they happen to be so frequently related that to some extent the action required to reduce one will lessen the other. Together these two diseases form the greatest removable obstacles in our midst to health, happiness and prosperity (Newsholme 1925:228).

In some cases this morality was expressed in a more scientific fashion.

> It is clear that the only sure way of avoiding such diseases is to avoid all risk of infection. It is equally clear that sexual promiscuity increases these risks and, on that and other grounds, is to be condemned. It is an accepted scientific proposition that the social and moral standards of a people, its national character, bear relation to its health, and such national standards and customs, and not the medical issue only, are the decisive factors in any practical solution (UK.Health 1920:60).

The regulation of sexual morality remained at the core of British public health activity around venereal diseases. The method for doing this, however, began to change. The grand aim of moral regeneration, however, was gradually being displaced by more modest goals. Increasingly, British public health aimed at more practical projects with more immediate results. The British Royal Commission on Venereal Diseases certainly included discussion of the need for moral elevation.

> If venereal diseases are to be stamped out, it will be necessary not only to provide the medical means of combatting them, but to raise the moral standards and practice of the community as a whole (UK.RCVD 1916:60).

The priority, however, was clearly to be treatment rather than education.

> Improvement in the moral standards and in social conditions may, however, be slow, and we are convinced that upon ample provision for early treatment and readiness to take advantage of it any real progress towards the diminution of these diseases as a most baneful factor in the national life must mainly depend (ibid:65).

Over the next two years, free treatment programmes were developed by 127/145 local authorities in Britain (UK.LGB 1918:lxv). Debates began to flourish in the public health

literature about other practical measures to reduce the rate of venereal diseases, such as sex education and prophylaxis (to be discussed below).

A global approach to moral regeneration was being replaced by a more fragmented aggregation of partial programmes. Broad environmental and eugenic theories received less attention[11]. Public health activity around venereal diseases in Britain was shifting from being one aspect of a project of elevation to being a limited programme including free, accessible treatment and specific propaganda goals. In the period examined here, this shift was in process, being somewhat more advanced in Britain than in Canada.

It is crucial to emphasize that this shift did not mean the purging of moral content from public health activity around sexuality. Rather, moral rectitude and scientific wisdom were invoked by officials to prop up the compulsory, monogamous, heterosexual family. This regulation changed form, however, as the era of more technical and fragmented economic and medical social policy succeeded the era of moral regeneration.

D. Contradictions in the Scientific Morality of the Family

The scientific morality of the family lay at the core of early twentieth century public health. The moral regeneration of the working class family on the basis of a scientific ideology was absolutely central to the public health project of nation

building. Yet the theory and practice of moralising the family was highly contradictory.

The moral standardisation of the working class family threatened to break down the boundaries between public and private realms. To press to far in this direction would be to violate the moral autonomy of the family. Yet this autonomy was absolutely crucial to the character of private family reproduction through the unsupervised domestic labour process performed by conviction. The primary aim of these regulatory processes had to be to inculcate moral standards to be enforced through self-discipline while maintaining the barrier between the private realm of moral choice and that of public regulation[12].

One way in which these contradictions were negotiated was to put morality on a scientific basis in the new hygiene. People were to be allowed their own convictions, but were to be sternly informed of the point at which moral transgression became a scientifically determined threat to health. Where religious appeals backed by other-worldly enforcement had failed, perhaps scientific appeals backed by the very worldly terror of diseases would succeed.

Another way in which this negotiation took place was through a division of labour between state and voluntary (though often para-state) agencies. This included not only the complementary relationship between public health and traditional moral agencies, but also the development of new agencies. First in Britain and then in Canada, a National Council for the Control of

Venereal Diseases (NCCVD) was established to conduct anti-venereal disease propaganda, in concert with state officials and through the use of state funds.

These contradictions become apparent in the examination of sexual regulation. State regulation was seen as necessary to stem the tide of self-indulgence producing broad moral decay and specific diseases. Yet the very act of regulation necessarily illuminated the darkest corner of the private domain, sexuality. Any opening up of sexuality threatened not only the domain of moral autonomy, but also the elaborate layers of repression surrounding its theory and practice in this period. Further, the line between self-control (as in 'mastery of passions') and self-determination (as in a free and intentional sexuality) was difficult to draw effectively.

In the past, sexual regulation had been handled through blanket censorship, sometimes combined with harsh repression. Venereal diseases were regarded as just punishment for those who had sinned (Clarkson 1913:563). The British Contagious Diseases Act had attempted to stem the spread of venereal diseases in the armed forces through the compulsory medical examination of any women suspected of being prostitutes in garrison towns, the detention in certified hospitals of those with venereal diseases, and the punishment of brothel-keepers harbouring diseased prostitutes (Petrie 1971:11-21).

The silence surrounding venereal diseases was a product of this earlier method of regulation. Fear and ignorance were the

logical result of systematic repression. Yet this very fear and ignorance created an atmosphere in which it was very difficult to treat or prevent venereal diseases.

Public health officials were faced with the delicate task of creating just enough openness to allow for treatment and prevention, without undercutting the morality upon which the repression had been based. One way of doing this was to challenge the old assumption that venereal disease struck only the guilty.

> That they [venereal diseases] are intimately connected with vicious habits is evident, but it is too often forgotten that large numbers of sufferers are absolutely innocent (UK.RCVD 1916:63).

Particularly prominent among these innocent victims were women.

> Every year in this country thousands of pure women are infected in the relations of marriage, and in many instances their conceptional capacity destroyed, and aspirations which centre in motherhood and children are swept away, and the holy office of maternity is desecrated...(Hastings 1914:211).

The protection of innocents, particularly women and their reproductive systems, was a far loftier goal than saving the fallen. Punishment of the guilty only drove them underground, interfering with treatment and prevention, and ultimately infecting the innocent. Public health could threaten to go after the guilty 'in a resolute spirit', but in reality punishment threatened to rebound.

> When from their course of life or by habitual, though clandestine, immorality, persons are found to propagating disease, they should be dealt with in a resolute spirit and prevented from continuing to be a menace to society. But

> speaking generally the evil is so widespread that nothing will be gained, but rather the reverse, by attempting all at once too drastic a course of action (Ont.RCVD&FM 1918:4).

This problem led to a vigorous debate concerning the pros and cons of compulsory notification and treatment of venereal disease sufferers. The Royal Commissions in Britain and Ontario both considered and rejected the use of compulsion except in the case of those in state custody (UK.RCVD 1916:49-53, Ont.RCVD&FM 1918:4-6).

Without compulsion and punishment in the treatment of venereal diseases, lifting the veil of secrecy from sexuality and providing free treatment could be seen as eliminating the risks associated with sexual transgression. This made education particularly important.

> But the fact that we recommend that free treatment should be provided for all sufferers makes it in our opinion all the more necessary that the young should be taught that to lead a chaste life is the only certain way to avoid infection (UK.RCVD 1916:61).

Education was itself problematic. The question of teaching explicit sexuality, especially to children, was highly controversial. Yet broad moralising, with no specific sexual content, was unlikely to be effective. The Ontario Royal Commission opted for a very cautious approach.

> The advisability of leading up to the subject of sex hygiene by gradual and almost imperceptible steps is evident if the pupil is to be brought to it naturally and in a way not distasteful to the pupil or to the parent (Ont.RCVD&MR 1919:18).

The approach recommended by the Vancouver Medical Association was cited, excluding altogether the use of the term

'sex hygiene' in the schools and instead introducing 'nature study' in public schools and 'applied biology' in high schools (ibid:18-19). The British Royal Commission was equally vague.

> The foundation should be laid in the elementary schools for fuller instruction and more effective help during the critical years of adolescence, when the combination of impulse and inexperience may lead to the most harmful results (UK.RCVD 1916:61).

The British Commission was careful to add that instruction in the schools, "...cannot relieve parents of their responsibility in this respect." State instruction and parental authority were in direct conflict in this area. Yet parentally-enforced ignorance was a significant impediment to improved venereal disease prevention.

It was not only the question of family autonomy which made sex education tricky. The threat of freer sexuality loomed under the open transmission of information in this area. The spector of sex for its own sake began to appear in public health literature calling for sex education.

> Modern scientific information regarding the function of sex indicates that, both in the physical and mental sphere, sex has, in addition to the racial effect of endowing the organism with the power of parenthood, a strong and penetrative contribution to make to the physical and mental efficiency of the individual (March 1921:218).

If sex education threatened to spill over into sex for its own sake, this was even more true of prophylaxis, preventive methods based on immediate treatment after sexual intercourse. Prophylaxis was clearly effective in reducing venereal diseases when practiced in the armed forces (Bates 1918a:54). Yet it also went a long way towards creating a situation in which the

consequences of sexual promiscuity for men (i.e. venereal diseases) would be eliminated. This technique offered nothing to women.

The issue of prophylaxis was hotly debated in British public health. In its favour was medical efficacy in fighting venereal diseases. "There is no single measure that can have anything like the influence of personal prophylaxis in eradicating these diseases..." (Joseph 1919:82). On the other side were the moral consequences.

> I cannot see that the policy of supplying prophylactic outfits, especially after illicit intercourse, can act otherwise than as an incentive to immorality (Smith 1919:83).

The contradiction in the regulation of sexuality around venereal diseases can be summed up as follows. Venereal diseases were a very real threat to national efficiency, as conceived by public health officials and other state policy-makers. The most effective methods to fight these diseases chafed against the compulsory family system, lifting the blanket of silence, reducing social stigma, offering some degree of sexual self-awareness, and protecting men from infection.

As with AIDS today, the state was torn between using the diseases as a regulator of sexuality by constraining the fight against them, or combatting the disease on the grounds of national health and risking damage to the compulsory monogamous heterosexual family. In the event, the Canadian and British states danced cautiously around the contradictions, attempting to enforce monogamy through education as a substitute for the terror

impact of the diseases. This contradiction in reality led to sharp debates regarding the regulation of sexuality within public health circles.

The shift in social policy towards medical and economic forms of regulation did not eliminate these contradictions. However, the increasingly technical character of these new forms of social policy pushed even farther in the direction of giving morality a scientific aspect. A scientific morality was implicit through the range of narrowly defined policy areas, but it tended to appear only in fragmented and partial forms.

4.2 Case Study 2: The Hygienic Family in Britain

The regulation of family life around the standards of scientific hygiene focussed on two key points. The hygienic home was to be created primarily by regulating the domestic labour of women through regimes of home visiting. The formation of a new generation free of the taint of degeneracy which indelibly marked their parents was to be accomplished through the school system and the monitoring of mother. Concerted action at these two points would break through the barriers of ignorance and demoralisation that impeded the elevation of the working class.

4.2.1 The Hygienic Home

The hygienic home was seen as the foundation of the healthy, scientific family. The basis of the hygienic home was the domestic labour of women as wives and mothers. The supervision of domestic labour was required in order to establish sound methods which could then, at least to some extent, be passed on autonomously through the family.

> ...once a generation of competent mothers and housewives has been brought into being, a family tradition would be created which would contribute to preserve higher ideals of domestic comfort and better standards of life (ICPD) 1904:42).

The central aim of public health in this period was precisely to create this competent generation, primarily through methods of persuasion. This involved a central contradiction. The family was the organization of working class self-reproduction. The material and ideological autonomy of the

family was central to this process of self-reproduction. The objective of public health was to strengthen, not weaken, this autonomy. Yet state intervention itself was seen by reformers as perhaps the greatest threat to the autonomy of the family.

Pattin (1909:40-1) stated that state standardisation involved "...the definitive subordination of the individual to the family, the class to the nation, the community to the race." The intensification of the private family system and the state regulation of reproduction were seen as parallel. State standardisation was to augment rather than to diminish both the material and ideological autonomy of the family. In practice, the relationship between the standardisation of family life and the autonomy of the family was constantly problematic.

The focus of public health shifted from the external environment of the home (sewage, water supply, urban design, road surfaces) to the internal environment.

> Formerly, the work of the public health administrator was chiefly concerned with what may be thought of for convenience as the external environment of the individual and the community...[now] the centre of gravity of our public health system is passing in some degree from the environment to the individual, and from the problem of outward sanitation to the problem of personal hygiene (UK.Bd of Ed 1908:15).

Even the old environmental concerns were redefined as threats to domestic hygiene. Newsholme described the impact of bad sanitation (inadequate sewage disposal, inadequate disposal of garbage, unpaved roads, lanes and back yards) on infant mortality:

> All these lead to dirtiness of the environment of the house, to treading of dirt, often of excretal origin, into the house, to a lowering of domestic cleanliness, and -what is perhaps worse - to the disheartening of the overworked mother, who wearies in her house-pride, which is constantly being thwarted by the terrible condition of things outside the back door (UK.LGB 1910b:63).

Sanitary nuisances, then, were a problem in that they contributed to the demoralisation of the home-maker. Previously, public health officials had stressed the direct threat to health posed by unsanitary conditions. The new public health of the early twentieth century aimed at the internal environment of the home, through regulating the labour process of its guardians: women.

A. Domestic Labour and Home Visiting

Domestic labour and wage labour are necessary complements under capitalism. Wage labour is supervised social production for capital, in order to earn wages which represent the value of labour-power, the cost of reproducing workers and their families. Domestic labour involves the consumption of wage goods through a process of unpaid unsupervised private production[13]. The primary task of public health during the period examined here was to develop a system to regulate this domestic labour without altering its basic dynamics. The method developed emphasized education, to establish standards, and inspection, to enforce those standards.

Domestic labour under capitalism has been primarily performed by women based on a historical division of labour by

sex. Public health officials saw this historical division of labour as a natural order. The violation of this natural order had health threatening consequences.

Home visiting was the primary method for the regulation of domestic labour, sending health workers into individual homes to instruct, supervise and inspect. The first programmes of home visiting in Britain were introduced by voluntary societies to promote cleanliness in the home. The first health visitors were organized by the middle class philanthropists of the Ladies Sanitary Association of Manchester and Salford in the 1860's. Wohl (1983:66) characterized these as middle class volunteers who, "...entering the homes of the poor, tried to scour the inhabitants as well as their flats." On the other hand, Frazer (1950:263) wrote that the Association, "...employed women of the working class to visit the poorer people and teach them the laws of health."

Similar programmes were developed elsewhere on a philanthropic basis. Municipalities became involved in these programmes in the last decade of the 19th century, taking over the responsibility for some aspects of health visiting in some localities.

The other route through which municipalities became involved in home visiting was as an extension of sanitary inspection[14]. J.S. Cameron (1902:743-49), the MOH for Leeds, submitted a report to his board in 1897 recommending the hiring of at least one woman sanitary inspector. If only one were employed, "...her

most obvious duties would be in connection with workshops and workplaces where women are employed." If more than one were hired other areas of work could be added, particularly visits to homes in which infants had recently died. These visits would include an orthodox sanitary inspection of the dwelling, as well as work oriented to domestic hygiene:

> It was suggested that in investigating these cases the woman inspector should make a very complete sanitary examination of the house and of the above-ground evidences as to the state of its drainage...One principal advantage of her visit would be her oversight of the condition of the house in regard to cleanliness - a matter in which, as it seems to me, a woman is apt to have a higher standard than a man (ibid:745).

Further, the women sanitary inspectors could advise on nutrition and "deal generally with the domestic side of hygiene" (ibid). Two women inspectors were appointed in Leeds in 1899; these had the same qualifications and received the same pay as male inspectors[15]. Cameron distinguished these women sanitary inspectors from health visitors:

> I was particularly anxious that they not take simply the position of health visitors, as in some towns, but that they should be thoroughly competent in every respect to discharge the duties of an ordinary ward inspector (ibid:747).

Not all public health officials agreed with Cameron that there was a place for women sanitary inspectors. Duck (in Richards 1907:200) advocated a strict sexual division of labour in public health work, in which sanitary inspection would be done by men and "all woman sanitary inspectors designated as health visitors."

Home visiting, then, developed out of philanthropic health visiting and orthodox sanitary inspection. While the two were not identical, the clear point of convergence was an emphasis on domestic hygiene. Health visiting emerged as the dominant model[16]. The aim of health visiting was clearly to improve women's domestic labour. Legislation applying to health visitors in London described their responsibilities as:

> ...giving to persons advice as to the proper nurture, care, and management of young children and the promotion of cleanliness and discharging such other duties (if any) as may be assigned to them (cited in UK.LGB 1910a:xix).

This broad focus on domestic labour was one of the great aspects of health visiting:

> There is no step, in short, towards training mothers in personal, domestic and infant hygiene, with which it cannot be associated, and towards the effect of which it cannot contribute (ICPD 1904:59).

It was largely taken for granted in public health circles that home visiting was to be done by women. The sexual division of labour in society (understood as natural by public health theorists) was reproduced within public health work. There were certainly debates regarding the sexual division of labour (within public health and society at large), however the general trend was to see it as a natural and immutable feature of the human condition.

Richards (1907:193-4) was an extreme proponent of the view that there was in essence a 'natural' sexual division of labour

in public health as in society:

> ...it seems to be too often forgotten that there are fundamental differences not only in the training, but in both the physical and mental capabilities of men and women, and that due regard should be paid to these differences in allotting to men and women respectively their true place in public health work.

Women were ideally qualified for home visiting:

> Now, it is just this ready wit and facility of expression that make women specially suitable for what one may call the educational side of public health work, such as the instruction of mothers in the care of their children and in personal hygiene (ibid:194).

Women were not seen as appropriate for other jobs. They were too soft to be trusted in material welfare work:

> ...while the ready sympathy of women is immensely useful when dealing with children, it frequently tempts them to take short cuts and give alms when they should have been content with exercising moral pressure... (ibid)

Further, women were not suited for the sanitary engineering side of public health as "...it is a matter of common knowledge that women, as a whole, have little taste for mechanics" (ibid). The article included a list of suitable jobs for women, many of which involved home visiting.

This article went further than most in extending what was seen as a natural sexual division of labour in society into the realm of public health. The printed discussion following his article showed that Richards' view was challenged (as well as supported) when the paper was read. Two contributors (one woman, one man) specifically took on the view that differences in

aptitude in areas of sanitary work were in any way inherent.

> [Miss Carey]...appealed to the lecturer not to judge women by what he saw of them in examinations. It was true that they were generally weak in sanitary engineering, but this was due not necessarily to want of capability or interest, but due to lack of proper instruction (ibid:199).

While some would challenge Richards' crude view of essential differences in capability between women and men, no one challenged the basic view that women were best suited to home visiting work.

> Women must have more experience in these things; they must know a great deal more of the lives of women and children than men can know (Farquharson 1902:166).

It was basically taken for granted that the logical people to deal with domestic labour, seen as women's work, would be women. It was not only the experience of women which qualified them for this work, but also the special woman's touch:

> Perhaps here (viz., in visiting the cases of consumption voluntarily, or as in Sheffield, compulsorily, notified) more than in any direction does the need for a woman's tact (i.e. touch) come in (Gardiner 1904:2).

In fact, specific experience was not the prime requirement, and there was certainly no expectation that health visitors should, for example, be mothers. In fact, there was in many ways a gulf of experience between middle class home visitors, employed outside the home, perhaps single and the working class mothers (employed or not) they sought to influence. Home visitors were to be the same gender as the women they were to educate, but not the same class.

The gap of experience between visitors and visited is

demonstrated by an 'old story' repeated by the Assistant MOH of Newcastle:

> ...[the story] of the poor health visitor who was asked by one of these sybils if she had any children, and on answering confusedly in the negative, was promptly told to go away, and not to come blethering about 'fresh hair and civilized milk' to a 'lady' who had buried seven bairns (Kerr 1910:129 see also Moore 1906:22).

The story expresses contempt for the ignorant woman who thinks that experience in child-rearing counts for something, who doesn't grasp the importance of fresh air and humanized milk and even gets the words jumbled, who has the gall to consider herself a 'lady' and who is almost proud of the deaths of her children. The kind of hostility expressed by this type of beneath-contempt woman was a common enough experience. "Most health visitors have been told something to the same effect, often enough" (ibid).

This kind of story demonstrates the gap between home visitors and the women they visited, despite woman to woman links. This gap was not regarded as problematic by public health officials, who tended to argue that home visitors were best drawn from the middle class.

Home visiting was in many ways an attempt to generalise the domestic standards of the bourgeois classes to working class women, though without the material resources that made such standards possible. Bowring (1894:413-4) told the Conference of Ladies on Domestic Hygiene that the key task was to raise the domestic standards of poorer women:

> How best to inculcate the desire for this improvement among our less fortunate sisters, how most wisely and sympathetically to impart such teaching as will conduce to a

> higher standard for their health and for their homes; should be, it seems to me, the keynote of our conference to-day.

At first, this was to occur mainly through philanthropic routes, with the direct participation of bourgeois women in the process of generalisation. The professionalisation of home visiting meant that the task of generalisation fell mainly to a corps of trained and educated middle class women employed by local authorities. The class background of these women was regarded as an important feature of their qualifications.

> The ideal woman for the work is a woman of position, education and strong character...a woman sufficiently above those amongst whom she works as to be unconscious to a great extent of the class difference and able to hold intercourse with the poorest classes without condescension, having that sort of easy dignity which permits a woman to talk to her fellow women simply from the womanly standpoint without regard to class, education, birth or income (Evans 1903:306).

It was not true that working class women would do a better job because of their links in experience and empathy to the women they visited:

> I am convinced that it is a mistake to suppose that more effect is produced by women of the cottager type than by competent and well-educated women (Hill 1906:366).

A middle class background would be a source of authority for home visitors:

> ...it is hoped, by the selection of ladies having not only understanding and tact, but also a responsible position, to overcome the prejudice in favour of the advice of grandmother or auntie...(Moore 1906:22).

This general background was not sufficient in itself, and was to be supplemented by specific training and examination through bodies like the Sanitary Institute (Evans 1903:306, Hill

1906:366). However, it was regarded as a useful starting point in this project of elevation. Swain (1903:127) described this important feature of home visitors: "They all tend to humanize, to educate upwards, to say nothing about the saving of human life."

B. The Method of Standardisation

The aim of home visiting was to establish standards for domestic labour through a combination of education to establish standards and supervision to enforce them. This was a very delicate operation as it aimed to develop compliance through conviction rather than compulsion.

Home visiting was the most important of the educational initiatives launched by public health in this period aimed at the domestic labour of women. Others included lectures, printed matter and school programmes. Home visiting was regarded as the most effective of these.

> The former [health visiting] is the best method for the diffusion of information on domestic economy, the rearing and feeding of children, house sanitation, and such like matters; and for this matter should be preferably carried out by ladies. (Carter 1906:48).

Most importantly, home visiting suited the privatised character of domestic labour. Lectures and similar methods relied on attempts to socialise domestic labourers, to bring them together. Thus, only the motivated (most likely the least needy) were inclined to show. Carter (1906:49) described a year long

lecture series which attracted about 10,000 people in all:

> The audiences consist mainly of the lower middle class and intelligent working-men with their wives. We fail to reach the very ignorant, or the very poor; but this is not surprising.

Home visiting, in contrast, reached everyone. Further, it could touch on any area of domestic hygiene, reproducing the seamless nature of the domestic labour process. This is a private labour process in which every individual is a generalist performing all of the discrete tasks (child care, cleaning, cooking, laundry)(see Luxton 1981:18). The home visitor could deal with all of these tasks.

> How to clean the room, to cook the victuals, to feed and dress the children - all these things come within her purview (Swain 1903:127).

It was, then, the only approach that could meet the needs of the woman in the home, working privately and in a general fashion. The key was to shape domestic hygiene through reaching the person primarily responsible for domestic labour. Evans (1903:309) wrote that the household must be approached through the "house-mother:"

> Convince her of her dirt, show her the way to be clean - if she once sees the necessity she will make the lives of the family a burden to them until they are clean too...

The education of the house-mother was the goal of home visiting. This education required tremendous person to person

skills.

> Praise, advice, sympathy, and even admonitions, severe strictures and threats, when tactfully administered, are a spur to the lazy, careless and indifferent, and a possible means of raising the indifferent (Dick 1904:883).

It was not simply a matter of transmitting specific facts and procedures. Part of the aim of the exercise was to raise the pride and morale of mothers, to give them a sense of mission.

> Girls need to understand what a high privilege is theirs, as mothers of future citizens, and the importance, not only to the home, but to the state, of the healthy upbringing of their infants (Tompson 1911:119).

1. The Calling Card

While home visiting had a general character, reflecting the seamless nature of domestic labour, it also had specific objectives. This was necessary on a number of levels. First, it managed to focus attention on the most important issue. For example, in the area of infant mortality, the focus was on breast feeding: "Of course, the prime object of the visitors will be to secure breast-feeding" (Moore 1906:22).

The specific focus also provided a legitimate reason for violating the autonomy of the home. In normal times, state agents had no good reason and no right to enter a private home. Home visitors needed a specific problem as a calling card, creating the situation in which broad advice about domestic hygiene might be well received.

The major calling cards used by home visitors in this period were notification of birth, cases of tuberculosis, the detection

of an ill child at school, and later venereal disease. In fact, the major argument in public health circles for the notification of diseases of ignorance was to permit home visits.

Public health officials regarded the notification of births as useful on two levels. It was a source of the kind of statistical information regarded as essential for the scientific advance of public health work. In terms of immediate improvement, however, the most important feature was that it identified new mothers to be visited.

> Much of the utility of the notification of births depends on the making of visits by tactful and judicious health visitors... (UK.LGB 1909:xxiii).

The home visit was to occur as soon as possible after the birth. Entry was to be secured through a process of gradually winning the mother's confidence.

> The visitor will call at the homes where births have taken place immediately after the receipt of notification...She will at first inquire in friendly way after the welfare of the mother and child, and will on subsequent visits attempt to influence matters for good (Moore 1906:22).

Notification was used similarly in the treatment of tuberculosis. The voluntary notification of cases of tuberculosis in Manchester was introduced in 1899. Notification was followed up by visits; first by the Assistant MOH and subsequently by "... health visitors of the Manchester and Salford Ladies Health Society, generally once a month..." (Niven 1903:267). Similar programmes were introduced in other localities[17].

Newsholme argued for a slightly different intervention. Patients were first to go to a sanatorium, for education in hygiene and lifestyle[18]. Home visits were to serve as follow up to a brief sanatorium stay.

> The habits of life thus initiated can be maintained by continued watchfulness and care under a private practitioner or in connection with a tuberculosis dispensary, and by the home visiting of a competent and sympathetic health visitor or nurse (UK.LGB 1909:234).

The school nurse or health visitor generally called on the home in order to follow up on medical inspection in school. As Kenwood (1905:142) stated, "A dirty and neglected child indicates the necessity of attempting to do something to improve the parents." Further, the effective follow up of parents was the only effective way to gain practical results in medical inspection.

> It is hardly too much to say that efficient 'following up' proves in many, if not in most areas, to be impossible unless the arrangements for the school medical services include the employment of a school nurse or health visitor appointed for whole or part time (UK. Bd of Ed 1910:97).

This follow up often had a specific agenda, an attempt to secure particular results.

> The experience of each year during which medical inspection has been in progress has served to bring out in stronger relief the place, importance and purpose of 'following up' the ailing or defective child until it receives the treatment of which it stands in need (UK. Bd of Ed 1911:98).

This process of 'following up' could involve the application of pressure. In Bradford, the parent of a child who had an illness detected through inspection was notified and told to take

the child to either a private doctor, a hospital, or the school clinic. This notification was followed up:

> Report is made as to what attention, if any, is being given to the condition, and pressure is brought to bear, and effectively, to ensure one of the above alternatives being carried out. Moreover, visits are paid in cases where it seems necessary to do so, to see that the attention given is regular, and parents who do not attend the clinic upon the days they are told, are also brought up to the mark in the same way (Crowley 1909:148).

This notion of 'bringing up to the mark' raises the whole contradiction of home visiting. The risk of creating an adversarial relationship was very high, given that this was an attempt to impose external standards on private labour albeit through voluntary compliance. Public health officials were aware of the risks, and constantly stressed the need for diplomacy and sensitivity.

Newman, the Chief Medical Officer of the Board of Education, was aware of these risks. He argued that repeat visits by separate officials (attendance officers, school nurses) could be counterproductive, and recommended the concentration of visiting in the hands of a single official (UK. Bd of Ed 1911:101). He urged that nurses arrive at the home literally as a visitor rather than as an inspector:

> A gratifying feature of the reports received is the frequent statement in regard to the manner in which the School Nurse is welcomed in the home. She appears almost universally to go not primarily as an official, but as a friend and counsellor, and her influence is proportionately great (UK.Bd of Ed 1909:78).

Similar caution was urged in other areas of home visiting.

Dick (1904:880) wrote that the female sanitary inspector, "...does well to be ever on the guard against hurting feelings." Hill (1906:386-7) stated that health visitors "...must first of all gain the confidence of the mothers, and gain entry into their houses." They might, however, face difficulties arising, "...from ignorance or from a fear that the health visitor is an inspector rather than a visitor..."

Each home visit was part of a process; gradually, cautiously winning the confidence and compliance of working class women. Implicitly, public health officials recognized the resistance of those being visited. Swain (1903:127) wrote of the woman sanitary inspector: "She is by degrees becoming a persona grata to the women of the slums."

The importance of sensitivity in tuberculosis visiting was particularly great, given that the tuberculosis patient was treated with a hysteria not unlike that surrounding AIDS today. Newsholme noted that the extension of compulsory notification for tuberculosis patients had been well-received, resulting in few victimisations:

> ...remarkably few instances of individual hardship, resulting from notification, have come to light. This has been in large measure owing to the tactful manner in which visits to notified patients have been made...(UK.LGB 1912:xliv).

All this consideration of the sensitivities of negotiating entry and attempting to influence does not mean that home visiting was not about enforcement. The concern was with the method of enforcement rather than the principle. In an area

where compulsion was not highly regarded, public health had to enforce standards through rather delicate and cautious methods.

ii. Enforcing Standards

The aim of home visits was to establish standards which would hopefully be internalised and then to enforce them through repeat visits. Dick (1904:883) wrote that the usefulness of home visitors was not just practical, but included the "abstract power of influence."

> The mere fact of knowing that there is such a woman at large in the district must have a salutary effect on some, at least, of the slovenly housekeepers (ibid).

The presence of the home visitor established a degree of accountability in the 'private' realm of the home. This accountability was reinforced through a cycle of education and inspection. Dick(1904:883) wrote, "Constant revisiting is the only key to improvement in ill-kept houses."

The character of this work as enforcement of standards is demonstrated by the use of words such as 'supervision' and 'oversight'. Newsholme argued that the benefit of a short educational stay in a sanatorium for tuberculosis patients "...may be lost if the patient is not kept under helpful supervision afterwards" (UK.LGB 1913a:lv). Cameron (1902:745) wrote of the woman sanitary inspector: "One principal advantage of her visit would be her oversight of the condition of the house in regard to cleanliness..." Charlesworth, a health visitor in Shoreditch, described her "faith in systematic re-visiting"

though arguing that the education of mothers was necessary but not sufficient (UK.LGB 1913B:71).

Through supervision, oversight or systematic revisiting, the aim was to impose specific standards on domestic labour. Morant, the Secretary of the Board of Education, described the development of these standards from luxuries to necessities to obligations:

> The fact is that things which are luxuries in one age become necessities for most people in the next age; and what have been necessities in one age become obligations in the next age; that is to say, they come to be regarded as things which must be made obligatory on those who are unwilling to regard them as necessary (Morant 1909:67).

Home visiting was the vehicle for making these things obligatory. However, the authority of these supervisors was different than those in situations of paid employment. The supervision of private labour was largely carried out through moral authority and repeated inspection (which dared not speak its name). As Newman wrote regarding public health work: "...true statecraft depends on an appreciation of the assent and consent of the governed" (UK.LGB 1919:vi-vii).

Of course, as in other aspects of the capitalist state, the threat of compulsion underlies 'true statecraft.' Given the particular importance of cooperation by conviction it did not surface often. One area in which it did surface was the 'enforcement of parental responsibility.'

> We require an Act of Parliament which will enable the sanitary authority, after a short notice, to have a child cleansed, to keep its head shaved, if its mother will not cleanse it, and some means must be found of compelling parental responsibilities to be fulfilled, or fulfilling them at the expense and to the advantage of the State, and also severely punishing the delinquent (Kerr 1905:62).

The discussion of compulsion and the enforcement of parental responsibility is continued in Section 2.6 below. The continuum of public health methods, ranging from advise to prosecution, was well summarised by Beatrice Webb (1909:161):

> ...there is, in short through the machinery of the health visitors and sanitary inspectors, the municipal milk dispensaries and schools for mothers, the medical treatment of school children and the visits of the school nurse - no little opportunity for preventing, by inspection, by advice, by exhortation, by compulsory removal, and, where necessary, by prosecution, many of these practices of neglect and self-indulgence which now result in much of the waste and expense of disease.

C. The Moral Standards of Domestic Hygiene

The central aim of home visiting was to promote the internalisation of specific standards. No amount of outside policing could substitute for the self-discipline of family members as policed by each other. Domestic labour remained a private labour process, and as such depended on the conviction of the labourer.

Moral concepts were a key vehicle for the transmission of the ideology of family discipline. The most important of these moral concepts were discipline, temperance and order. The scientific morality of public health founded on these concepts was not a substitute for traditional moralities, but a supplement which extended the structured hierarchy of the heavens right into the home.

Kenwood (1905:141-2) wrote: "The training in the observation of sanitary precepts is a form of moral training..." This moral training was required due to a decline in traditional morality, and a general failure of discipline in urban conditions.

> The vast majority of these poor women have little conception of the meaning of discipline, obedience or order, they are alas! incapable of forming character, as a rule they have no ethical substitute for the religion which so many of them have lost: muddle, dirt, stupidity and inefficiency constitute the environment of the great mass of homes we are anxious to preserve (Fritchard 1912:624-25).

A firm moral foundation was required to overcome ignorance, dirt and squalor. The material causes of these conditions were not denied, but were seen as inseparable from moral standards.

> Although I am profoundly convinced that lack of moral grit is at the root of most of our social problems, and is largely responsible for the misery and social evil which we see around us, I am aware that it would be absurd to ignore or to undervalue other contributing causes, economic, physical and environmental (Harris 1911:613).

Moral elevation was seen as an essential feature of any programme of improvement. Without the development of character and moral rigour, material reforms would achieve little.

> Provided you could possibly rescue these people from their degrading surroundings, and put them to live in palatial residences, before six months had elapsed they would have reduced their palaces to hovels. Instead of abolishing your slums, reform them. And your reform must be on two lines- reconstruction and firm control (Swain 1903:126).

1. Discipline

The failure of discipline created problems of ignorance and material mismanagement for working class families. Only discipline could ensure that education and material improvement were put to proper use.

> In regard to this great hindrance to health reform [i.e. ignorance] I would again point out the excessive difficulty of imparting either to the undisciplined adult or child any teaching which will be assimilated sufficiently to be put in practice in daily life (Harris 1911:615).

Similarly, domestic discipline was required to ensure that increased material resources were put to the right use.

> The very growth of the family resources, upon which statisticians congratulate themselves, accompanied as it is frequently by great unwisdom in their application to raising the standard of comfort, is often productive of the most disasterous consequences (ICPD 1904:15).

The greatest concentration on the development of discipline was to be in the schools. This will be discussed in Section 2.2

below. Work in the schools was an important way to break the transmission of indiscipline through the generations.

> ...these undesirable practices denote failure in moral self-control. Such failure is both the outcome of indiscipline on the part of the adult...and the cause of similar indiscipline in the infant and young child (Harris 1911:614).

ii. Temperance

Public health officials shared with other reformers a concern about the proliferation of what was perceived as self-indulgence in the working class. There was a fear that the working class was developing an incurable craving for cheap sensation.

> The desire for pleasure is stated to be another fruitful cause of the withdrawal from working class budgets of money that should devoted to the purchase of food. Other witnesses spoke of the taint with which the love of amusement was infecting large sections of the population, especially amusement in the form of cheap excitement, the desire for some sort of sensation, comparable to the aforesaid dietary of pickles and vinegar (ICPD 1904:41).

This self-indulgence expressed itself in various ways; most importantly through alcohol and sex. The alternative to this was what one official called "...the golden virtue of temperance in its widest sense" (Sully 1905:33).

In this period, public health officials tended to link a whole range of ailments and disorders to alcoholic indulgence. The Royal Commission on the Care and Control of the Feeble-minded concluded that there was an undeniable link between alcohol and mental handicap. The Commission chose not to endorse or reject theories which claimed alcohol was the cause of mental disorders, particularly on eugenic grounds. Rather, the link had to do with

a factual correlation between alcoholism and mental handicap (without any causal explanation) and the effect of alcohol on disorganizing the home:

> It is sufficient to insist on the salient and incontrovertible facts that many inebriates are mentally defective; that many mentally defective persons are specially liable to suffer speedily, seriously and permanently from the effects of alcohol; and that in any case alcohol in the parent leads practically to many evils in the family by destroying the organization of the home and bringing about neglect, ill-treatment, starvation and disease among the children (UK.RCCFM 1908:135).

Similarly, the Royal Commission on Venereal Diseases linked alcohol to sexually transmitted diseases:

> Abundant evidence was given as to the intimate relation between alcohol and venereal diseases. Alcohol renders a man liable to yield to temptations which he might otherwise resist and aggravates the disease by diminishing the resistance of the individual (UK.RCVD 1916:31).

Alcohol abuse was also linked to infant mortality (McCleary 1903:566, UK.LGB 1913b:78), the housing problem (Newsholme 1925:159), etc. The twin condition to alcohol abuse in terms of self-indulgence was sexual promiscuity spreading venereal diseases.

> Alcoholism and venereal disease are the chief examples of disease caused by directly anti-social conduct...Together these two diseases form the greatest removable obstacles in our midst to health, happiness and prosperity (Newsholme 1925:228).

The lack of self-control, with a specific moral dimension, was one of the major problems linked at the time to mental handicap[19]. People who were mentally handicapped were seen as a

moral danger to themselves and others:

> We find, also, at large in the population many mentally defective persons, adults, young persons, and children, who are, some in one way, some in another, incapable of self-control, and who are therefore exposed to constant moral danger themselves and become the source of lasting injury to the community (UK.RCCFM 1908:6).

This moral danger had a clear sexual dimension. Mentally handicapped women were seen as particularly liable to be taken advantage of and pushed into prostitution.

> It will have been evident that the aberrations of mental defect and disorder often take the form of sexual offences and impropriety, and that feeble-minded women and girls are especially liable to be taken advantage of by the vicious (UK.RCCFM 1908:154).

Venereal disease was also linked to lack of sexual self-control[20]. Newsholme (1925:238-9) wrote that preventive work in the area of venereal diseases involved, "...no less than the creation of a higher general conception of morality ..." This morality was grounded in self-restraint:

> The moral argument for chastity is alone consistent with the strength, beauty and joy of an admirable life; though it is occasionally necessary to deal with the incontinent in tender pitifulness, which is a faint reflection of the care which a mother bestows on her infant before he has learnt to control his excretory functions (ibid).

The aim of public health in this area was to subordinate the body to the disciplined mind[21]. Temperance, thrift and self-reliance had to be promoted in a working class bent on spending itself in every way. This was not simply a propaganda crusade against moral decay. Public health officials demonstrated again and again a rejection of an overly facile idealist causality.

The moral problems of the working class were seen as linked to material conditions. The increased amount of alcohol abuse among employed working class women was the result of low pay and long hours meaning that they could not feed themselves properly:

> The drink habit is too often formed by women as a result of this systematic semi-starvation; many are thus led by easy and swift stages to moral and spiritual ruin (O'Kell 1902:851).

The poor state of nutrition among members of the working class was an important factor in creating moral decay:

> ...whilst it is not intended to imply that improper nutriment is the only cause of the moral aberrations which are unhappily the rule and not the exception...there is no doubt that the outward manifestation of such impulses is conditioned by the body, and that degeneration, physical and moral, must be the inevitable result of failure to obey the laws of sound hygiene and simple nourishment (Hodgkinson 1902:852).

The Interdepartmental Committee on Physical Deterioration, despite its emphasis on irresponsibility, self-indulgence and ignorance, clearly connected alcoholism to conditions:

> The close connection between a craving for drink and bad housing, bad feeding, a polluted and depressing atmosphere, long hours of work in overheated and often ill-ventilated rooms, only relieved by the excitement of town life, is too self-evident to need demonstration, nor unfortunately is the extent of the evil more open to dispute (ICPD 1904:30).

Similarly, the sexual amorality of working class families could be linked to living conditions:

> The terrible state of things that does exist, with regard to the sleeping arrangement of many cottages, is not realised by the community at large. It is certain that the adequate housing of these people, with a view to the maintenance of decency, will have a great effect on the moral elevation of the nation (Foard 1903:847).

Public health officials tempered their disapproval of sexual promiscuity to decry the high death rate for infants born outside of marriages (see UK.LGB 1910b:46). In general, then, the whole question of self-indulgence was not reduced to one of moral decay. Moral decay was, however, a significant factor to be addressed. Internalised behavioural codes were a major element in the regulation of the family.

iii. Order

The concern with order and cleanliness among public health officials was not limited to eliminating the spread of germs. Order and cleanliness were prized in themselves, as the basis for healthy and disciplined bodies and minds. Cleanliness, for example, was a crucial foundation for pride and confidence.

> The education, however, of a child has seriously failed in its objective if it has not engendered a habit of cleanliness, one of the most important agencies in fostering the feelings of self-respect (UK. Bd of Ed 1906:45).

Order had to be restored to every aspect of domestic life, now victim to ignorance and folk-myth. Eating habits, for example, had become chaotic:

> And the best hope for the race is, that law and order should take the place of the chaos of ignorant indifference in which we have hitherto been content to leave a matter which concerns every one of us [i.e. nutrition]... (Hodgkinson 1902:52).

This conception of order and cleanliness was inseparable from that of structured hierarchy. While the saying might be 'Cleanliness is next to godliness,' there were in reality crucial

mediators between the heavens and the home. Order was a socially established standard, intimately linked to authority.

> Now I maintain that children brought up in an atmosphere charged with frequent and audible questioning of authority- parental, governmental and even divine - and under physical conditions where hardihood and the overcoming of dislikes and difficulties are eliminated from infancy to adolescence, and where the theory of self-development is unduly exaggerated, will grow into highly individualized, egotistical, undisciplined and unenduring adults who will resent all control of the physical and or moral conditions of life, and who will lower instead of raise, the standard of public health (Marris 1911:620).

The most important feature of authority in the case of the family was the internalisation of standards of self-policing. Discipline, temperance and order were the cornerstones for a sound private domestic labour process. Home visitng was to engender and reinforce these internalised standards, but not to substitute for them.

D. The Sexual Division of Labour

One of the key tasks for public health in the area of domestic labour to shore up the sexual division of labour. There was some debate among officals regarding the basis and degree of perceived differences between men and women. There was, however, near unanimity that scientific hygiene required the 'freeing up' of women for doemstic labour and the elevation of the positon of women as home-makers.

In the early twentieth century, this sexual division of labour was perceived to be under threat. The maternal instinct was being weakened through the spread of bottle feeding, the

schooling of women and similar developments. Increasing living standards among the working class were allowing women to become self-indulgent and lazy. The paid employment of women outside the home undermined family life. Attacking these threats to the sexual division of labour was a major priority for public health:

> Here is the crux of the whole matter. Restore to woman her natural mode of life, awaken in her the maternal instincts which a higher civilization has obliterated, and then, though we may be aware of the transmutation of man, we shall hear but little of deterioration (Duke 1905:257).

The emphasis on the sexual division of labour in public health focussed largely on the role of women as mothers[22]. The mother-child relationship was regarded as perhaps the supreme natural relationship:

> The mother is the natural guardian of her child, and no other influence can compare with hers in its value in safeguarding infant life (UK.LGB 1910B:70).

Motherhood was regarded as the natural lot of women.

> ...any change for the better must be commensurate with the spread of knowledge of infant hygiene amongst mothers and those who in the natural course of things will become mothers (Porter 1901:345).

New developments in society took women away from domestic life, undermining the mother-child relationship. Even tragic circumstances could improve this situation by forcing women back into the confines of the home. DeChaumont noted that infant mortality had declined during the American Civil War, "...because there was little else for mothers to do than to attend to their homes and their children" (in Hamer-Jackson 1904:436-9).

Modern women too often felt themselves above these laws of

nature. Bottle feeding was perhaps the most important feature of this weakened maternalism:

> The laws of nature, which so many of the modern women hold in supreme contempt, further demand from the complete woman the capacity and will not only to bear children, but also to nourish their infants in the natural way (Duke 1905:260).

Education was also impeding the natural development of girls into wives and mothers. Girls were receiving the same education as boys:

> The large majority of girls have only one occupation in their after-life [i.e. after completing schooling] - that of becoming the helpmeets of men and the future mothers of our race; yet in educational matters the tendency - nay, I believe the practice - largely obtains of educating them in secondary schools very much along the same lines as boys, ignoring altogether the sexual difference (Carmicheal 1906:432).

This education actually disabled women. It "...renders them less able to bear the strain of duty in after-life, more especially with reference to the all-important function of maternity" (ibid). It was not only secondary education that threatened to weaken the maternal drive in women:

> Also, I would ask you to consider whether by taking the child out of the mother's hands for the greater part of the day at so tender an age as three years, we may not probably have weakened the maternal instinct, and thereby have increased , and even caused in some cases, that parental negligence which nowadays we so loudly deplore (Marvin 1906:70)

Instead of education, women and girls needed practical preparation for their tasks in life, particularly the 'all-important function of maternity'. "To my mind, the hygienic training of girls should be primary, the intellectual of secondary importance" (Carmicheal 1906:433, see also Londonderry

1905:21). Newsholme wrote about domestic education: "It is, however, specialised education which is required for the successful rearing of infants, not skill in pen-writing" (UK.LGB 1910b:72).

This preparation of women for motherhood and domestic labour was to be physical as well as mental:

> For married women perfect physical condition is of the first importance, for the comfort of their homes, the welfare of their children, and of the nation generally depends on it (Pace 1904:871).

Poverty was another obstacle blocking the proper maternal development of women. Low sanitation standards lead to "...a disheartening of the overworked mother, who wearies in her house pride...(UK.LGB 1910b:63, cited above p.233)[23]. Material reform was necessary along with education to sweep away the impediments to the blossoming of maternal womanhood.

Along with these material impediments to the fulfillment of women's domestic role were ideological ones related to self-indulgence in a climte of moral decline. The Interdepartmental Committee on Physical Deterioration repeatedly discussed the failing self-discipline of women. Alcoholism, previously a problem of the male working class, was now affecting women:

> The tendency of the evidence was to show that drinking habits among women of the working classes are certainly growing, with consequences extremely prejudicial to the care of the offspring, not to speak of the possibilities of children being born permanently disabled (ICPD 1904:31).

Work outside the home was seen as a major 'predisposing cause' of this phenomenon (ibid). On top of this increased boozing, the ICPD pointed to increasing carelessness, laziness

and self-indulgence in material things affecting British wives and mothers. This view of growing laziness and indulgence among women was not universally accepted. However, whether or not laziness and self-indulgence were growing problems, the indiscipline of women in the home remained a crucial basis for bad domestic routine such as dirt and incorrect feeding of children:

> ...these undesirable practices denote failure in moral self-control. Such failure is both the outcome of indiscipline on the part of the adult...and the cause of similar indiscipline in the infant and young child (Harris 1911:614).

The paid employment of working class women was regarded as perhaps the greatest threat to the natural division of labour on the basis of sex. It undercut women's commitment to domestic labour (attacking the real glue holding the family together) and threatened domestic economy:

> When the mother works in a mill the house is necessarily neglected, the home must inevitably suffer, the husband is led to spend time from home, has funds at his command, extravagant habits (to say the very least) are contracted, the wife has no time or desire for economy (Tompson 1911:115-16).

Further, the paid employment of women weakened the work ethic among working class men:

> In her own district there were many laundries, and it was a common observation that many of the men there were loafers whose great object in life was to marry one of those laundry girls, who would after marriage continue to work and support the husband (DeChaumont in Hamer-Jackson 1904:438-9).

Not all paid employment was seen as equally threatening. Employment in domestic service was close enough to private

domestic labour to be potentially beneficial. Factory employment, in contrast, had nothing to offer women.

> ...comfortable homes are as a rule to be found among the working classes where the wives have had the advantage of this training [in domestic service]...factory operatives are, on the other hand, said to make the worst wives (ICPD 1904:43).

The paid employment of women was primarily a threat to motherhood. The physical health of pregnant women was at risk in the workplace:

> How can it be possible for a woman to give birth to a healthy child, when misery condemns her to hard labour at a factory, laundry or similar work, badly paid, incapable of feeding herself according to her state of health, and living the greater part of her life in the most impure atmosphere till the very day her child is born (Hamer-Jackson 1904:431).

The mother's absence would damage child care:

> ...for it cannot be conceived that the absence of mothers from home for a large part of each day can be free from danger to their infants, besides injurious to their older children, who are being deprived of maternal care and are insufficiently or improperly fed as the result of the mother's absence (UK.LGB 1910B:59).

The call for the abolition of the paid employment of mother was common in the public health literature:

> It should be a great source of protection to infant life and health if suckling mothers were not allowed to leave their infants to follow employments (Carpenter 1906:137).

This call was tempered by a realistic appraisal of the situation which compelled women to work.

> The ideal is, of course, that men should work and women should remain at home to bring up their own children, but while we should not lose sight of this, we must in the meantime take means to prevent the children of the nation suffering more than can be helped, from the apparently unavoidable state of the labour market (Gaffikin 1908:224).

This realistic appraisal led to a tendency to reluctantly admit the need for material alternatives for working class mothers. These ranged from some other source of income permitting mothers not to work, to the provision of day care for children of working mothers:

> It would undoubtedly be a wise provision of the state if pecuniary inducements could be offered...to prospective mothers stricken in poverty, and who are in need of them, to abstain from working for a considerable period before confinement, to remain absent from work for a longer period than is at present required by law, and to nurse their children at the breast (Moore 1906:22).

In the absence of such 'pecuniary inducements', the only alternative was to offer some sort of child care for the offspring of working mothers. This alternative was considered reluctantly as it threatened family responsibility:

> The idea of relieving a mother of this duty is opposed by some, but the nursery would not supplant but supplement the mother who is obliged to go to work, and would prevent the child from being the victim of these circumstances (Moser 1903:764).

However, the nursery or creche was also conceived as a way of fostering family self-reliance, given the actual material circumstances of many working class families:

> The creche helps the poor to help themselves, and benefits the family by setting the mother free to go to work and increase the family earnings, and in some cases to provide the only earnings for the whole family (Hunt 1905:105).

A practical assessment showed that daycare was preferable to the child-minding arrangements that working class families were making for themselves: "No such provision being made, the child is generally left to a neighbour - often old, ignorant and very poor" (Moser 1903:764). Public health officials certainly did

not argue for child care from the point of view of women's liberation, but rather as a practical necessity dictated by regrettably unchangeable economic circumstances. Nevertheless, the realistic assessment of the conditions of working class women did lead some public health officials toward the socialisation of aspects of domestic labour[24].

Not all public health officials were willing to reconcile their ideological view of the centrality of the family with the material realities of working class life. The social scientific evidence assembled by public health officials increasingly indicated that poverty was a more significant factor than maternal employment in causing infant mortality.

> Formerly, [the employment of mothers] was almost universally held to be an etiological factor of preponderating importance; but the application of more precise methods of investigating has cast grave doubts on this view, and has called for a restatement of this whole question (PH Editors 1910:229).

An influential report by the Birmingham MOH, John Robertson, showed that the infant mortality in poorer districts was lower in families where mothers were employed:

> The whole report emphasizes the importance of the economic factor in the etiology of infant mortality, and it will strengthen the position of those who hold that, under existing conditions, any further state interference in the industrial employment of married women would aggravate rather than alleviate the very evil [they seek to remove] (PH Editors 1910:229).

Some influential public health officials resisted such conclusions. Newsholme wrote regarding Robertson's report, "It would be folly to infer from this that the industrial occupation of mothers is not a most injurious element in our social life"

(UK.LGB 1910b:57). The dramatic increase in the industrial employment of women provided evidence on a broader scale that the income produced by paid employment was more important in lowering infant mortality than the absence of the mother.

> The lowering of the mortality in infancy is all the more surprising in view of the increasing number of women having young children, who have taken up industrial work (UK.LGB 1918:xxxv).

In short, the opposition of public health officials to the paid employment of married women was in large part ideological, stemming from a theoretical position which elevated the sexual division of labour from a social product to a natural law. Evidence to the contrary did put cracks in the 'almost universal' conviction that the absence of the mother was a major cause of infant mortality. It failed, however, to convince at least some influential public health officials that maternal employment was not harmful.

The other side of the perpetuation of the sexual division of labour was the development and regulation of male behaviour in men and boys. This activity generally fell outside the purview of public health proper. While they could do little about it directly, public health officials called for various programmes to turn boys into men:

> Not only should girls be taught the domestic virtues in our public schools, but boys should be trained in all the essentials that produce good citizens and good fathers- respect for parents, cultivation of the natural affections, the love of home and country, duty to one's neighbour, personal cleanliness, obedience and decent behaviour, and the leading of well-regulated lives (Carpenter 1906:137).

These programmes, insofar as they were directed at children, will be discussed in Section 3 below. Essentially, males were to be mentally and physically prepared for wage labour and war, while women were prepared for domestic labour.

Men and women were seen as having different moral capacities. Women were seen as the chief repository of morality in social behaviour. This was something they would have to learn to generalize. Women were to play a leading role in the 'purification of the moral atmosphere'.

> This is preeminently work in which women must take their share...To guard the welfare of the home, the standards of the home must be applied to the affairs of the community; and in this task, woman, the guardian of the home, must have her share (Wilson 1911:345; see also Barr 1911:716).

Just as the woman as guardian of the home had to watch over the morality of the man in her family, so the man as head of the household had to supervise the labour of women in the home. A man was not wise to be his own doctor or lawyer, but he could be the sanitary inspector for his own household:

> ...I do think it is possible for every man to be his own sanitary inspector - at any rate, to be his own inspector to this extent, that he can and should look after his own health, and where he is placed in a position of responsibility, having control over others - as in the case of a father of a family or an employer of labour - he should as far as possible look after the health and well-being of those committed to his charge (Pilkington 1902:277).

The parallel between the role of the employer of labour and the head of household was one of supervision. While the woman was to supervise moral behaviour, the man was to oversee the domestic labour process, to ensure that 'his' house was kept in order.

B. Contradictions in the Regulation of the Home

The regulation of the domestic labour process was necessarily contradictory. The capitalist family system is founded on domestic labour, a private labour process in which commodities obtained through wage-labour are consumed. Central to this process is the ideological and material autonomy of the family. Ideological autonomy is crucial, as this process is fundamentally maintained by conviction, by the willingness of family members to reproduce themselves under specific circumstances. Of course, this conviction is organized through a range of social mechanisms, of which an increasing proportion fell directly within the purview of the state during this period. Nonetheless, private labour by conviction is an absolutely crucial component of the system; and no amount of external policing could substitute for this. Yet, public health officials were convinced in the early twentieth century that domestic labour was simply not up to par.

The material self-reliance of the family is in fact dependence on the wage obtained through the capitalist labour market. In this period, almost any form of direct material assistance was seen as undercutting the drive to wage-labour, hence threatening the self-reliance of the family. Yet, public health officials recognized that wage levels and market forces meant that many families could not afford to reproduce themselves.

Public health, then, was faced with the task of overseeing domestic labour, recognizing and perhaps acting on real material obstacles, all without disrupting the autonomy of the family or its dependence on the wage form. Officials were aware of the delicacy this required. The health visitor, for example, was described as being 'tactful and judicious', 'friendly', 'sympathetic', and displaying 'understanding and tact' or 'a woman's tact'[25].

Public health officials justified the 'invasion' of the home on the grounds that the problem of poor household management had direct ramifications for the national interest:

> We in this country are notoriously averse to the invasion of the public official into our home life. We leave a wide discretion to the parent even in the matter of the care of the health of his children. But in conserving this wide freedom we must remember that unwisdom on their part in matters regarding the health of children falls upon our citizens of the future, for they are our children of today (Sherrington 1902:311).

Too many households were being run in a substandard manner:

> I was myself a strong believer in the sanctity of the home and the value of its individualism until in connection with the medical examination of school children I came into contact with several thousands of their mothers....muddle, dirt, stupidity and inefficiency constitute the environment of the great mass of homes we are anxious to preserve (Pritchard 1912:624-5).

In normal situations, the family should operate autonomously to provide the best for all its members. However, widespread ignorance meant that many families were incapable of healthy self-reliance.

> Now, although the child's health and well-being is best and properly entrusted in these matters to the intelligent

> parent, there is in many homes no intelligent parent... (Sherrington 1903:29).

The protection of children was the primary justification given for the intervention into the family. This was to be done in such a way that the parental responsibility for children was not undercut. Newsholme (1905:66) wrote regarding his experience in the medical inspection of school children: "We have carefully enforced the rule that no responsibility must be removed from parents." This specific rule in medical inspection was also a general rule for public health.

Far from undermining parental responsibility, public health officials saw themselves as enforcing it[26]. The aim of intervention was not to substitute for the self-maintenance of the family, but rather to make it happen. Beatrice Webb (1909:161) argued along these lines for the expansion of public health activity:

> We advocate this reform because we believe we shall thus curb physical self-indulgence, increase the care of the child by the mother, the concern of the husband for the wife, and positively heighten the desire and capacity of all persons to maintain themselves.

The medical inspection of school children was one of the areas in which the enforcement of responsibility was most explicitly discussed. A Board of Education memorandum regarding the introduction of medical inspection stated:

> One of the objects of the new legislation is to stimulate a sense of duty in matters affecting health in the homes of the people, to enlist the best services and interests of the parents, and to educate a sense of responsibility for the personal hygiene of the their children. The increased work undertaken by the State for the individual will mean that

> parents have not less to do for themselves and their children, but more (cited UK.Bd of Ed 1908:32).

Generally this enforcement of responsibility was to occur through a process of education and moral suasion, though compulsion was also to be used:

> The neglect of parental duties I hold to be an unnatural offence, in which there should be no squeamishness or sickly emotionalism about effecting compulsion (Kerr 1908:62).

This type of intervention was still problematic. On the one hand, public health wanted to improve the performance of the family as a repository of traditions of self-help and morality. On the other, it sought specifically to undermine family tradition and replace it with scientific knowledge. The Assistant MOH for Newcastle dismissed the advice of grandmothers in the following terms:

> ...I wonder what percentage of infantile mortality is directly attributable to the baneful influence of this infanticidal expert (Kerr 1910:129).

This meant weakening certain lines of authority within the family. Moore (1906:22) argued that home visitors must have sufficient authority to "... overcome the prejudice in favour of the advice of grandmother or auntie..." This erosion of family authority took its most extreme form when public health attempted to use children as agents to attempt to change the habits of their parents (see above p.194). A representative of the National Health Society argued that mothers should be taught hygiene rather than their children:

> [Mothers] did not like being told things by their children. It made the children rather insubordinate, too, to be set to teach their parents or 'teach their grandmothers.' They

> knew so much more than their parents now, they got to look down on them (Dowding in Hill 1906:372).

The public health agenda risked upsetting relations of power and authority that were fundamental to the family form. While the labour of self-reproduction might be primarily motivated by conviction, it was daily regulated by structured hierarchical relations within the family and society. Public health had to upset some of these traditional lines of authority which transmitted bad habits, yet without creating an environment "...charged with frequent and audible questioning of authority-parental, governmental and even divine..." (see Harris 1911:620 cited above p.45).

One of the areas in which this was most problematic was in male-female relations. As stated above, public health aimed to reinforce the sexual division of labour. Yet it aimed to do this in such a way as to strengthen women in their traditional role. This meant using the moral force of women:

> Women set a high moral standard for themselves; of course there are exceptions, vile exceptions. Now, I wish them to set a high moral standard for men (Barr 1911:716).

Yet the man was seen as the head of the household, "in a position of responsibility, having control over others" (see Pilkington 1902:277, cited in full p.43). Public health officials did not aim to undercut the privileged position of men: "It is not intended that in these matters women should trench upon the province of men... (Bowring 1894:414). Yet the strengthening of women, even in their traditional roles, did have implications in terms of gender and power. Within the bounds of

public health proper, this meant the admission of women to male-only professional associations and support for women's suffrage as a basis for sanitary agitation[27]. More broadly, it meant enpowering women at least to the extent where they could begin to influence the domestic environment.

The difficulties faced by public health at the level of material intervention were perhaps greater than those at the ideological. Public health officials believed that material changes were required to put the working class in a position to reproduce itself properly. Yet any improvement in material standards which did not come by way of wage labour threatened to create pauperism, the insidious disease of dependency.

One of the most important examples of this dilemma was in the area of the nutrition of schoolchildren (the other was housing). Public officials were clear that decent nutrition was an absolute prerequisite for effective education and industrial productivity:

> We are a nation of workers, but we cannot, any more than the Hebrews of old, make bricks without straw; and, if the schoolmaster finds underfeeding so closely associated with unsatisfactory educational results, it is logical to assume that some part, at least, of our industrial inefficiency has a similar origin (Chalmers 1905:55).

Yet to feed children was a threat to the self-reliance of their parents:

> The provision of food for school children may, by undermining the already enfeebled efforts of parents to support their children, eventually do more harm than good...The wholesale provision of meals is not the best means of improving the physique of the school children, though such meals may be necessary in carefully selected cases (Newsholme 1906:87-8).

There was a place for state provision, but generally only in areas where parents could not be expected to provide for themselves:

> Education is a great social need, which individual citizens are, as a rule, not able to provide for their children on a sufficient scale, but food, like clothing and lodging, is a personal necessity, which in a well-ordered society, it is not inherently impossible for parents to provide; and the effort to supplement their deficiencies, and to correct the effects of their neglect, should aim, in the first instance, at the restoration of self-respect and the enforcement of parental duty (ICPD 1904:72).

The priority, then, in terms of seeking to improve the nutrition of school children was to change the home:

> The proper and sufficient feeding of the child is primarily the function of the home, and it is to the gradual improvement of the home that the Local Educational Authorities must primarily look for relief from the special difficulties which confront them through the malnutrition of the child (UK.Bd of Ed 1910:258).

Newman argued that school meals should only be given where the physical condition of the child (as opposed to financial condition of the parents) indicated that it was a medical necessity. Particular attention was to be paid to the educational side of the feeding programme, and to follow up activities which monitored the medical effect of the meals (UK. Bd of Ed 1912:274,283).

The reluctance concerning school meals was overcome fairly quickly, most importantly through the experience of local programmes. The same pattern of extreme reluctance regarding material reform, a period of cautious local experimentation and then generalization, tended to occur in each area where non-wage maintenance was proposed.

Of course, like other social reformers in this period, public health officials did not share a unanimous view of correct levels of material assistance. One President of the Society of MOHs, for example, advocated a far more sweeping vision of material provision:

> Effectually to standardise our national life we shall need not only to require, but as a people to provide, all agreed upon minimal essentials of a healthy existence, e.g. of food, clothing, housing, education, medical aid, etc (Pattin 1909:40).

Pattin (ibid:41), who argued that MOHs should be "philosophical sociologists as well as professional sanitarians" went farther than most in his explicit arguments for non-wage maintenance. However, advocates could be found among the ranks of public health officials for state housing, mothers allowances and other benefits.

The ideological and moral interventions into the family were inherently contradictory. While they could provide the basis for substantial improvements in family life, they also threatened the moral and ideological autonomy of the family. This fundamental contradiction had reverberations throughout public health activity on the family.

4.2.2 The Next Generation

The education of children was seen as perhaps the most promising of all public health activities in the area of the family. The emphasis on children reflected the basic environmentalist orientation of public health officials. Caught early enough, children could be trained in hygienic living without the baggage of bad habits and traditions that limited the learning capacity of adults. Pilkington described it graphically when he wrote: "...it was easier to raise a good crop on virgin soil than to remove the roots of deep-seated ignorance and bad habits handed down from others" (in Hamer-Jackson 1904:435).

Children were not yet ruined physically, mentally and morally. The best way in to the whole cycle of degeneration was to form a genuinely healthy generation which could then reproduce itself with minimal interference. Public health hoped to make the school the site for shaping the next generation, through medical inspection, physical drills and hygiene education. The school was the best place to break the transmission of bad family traditions and replace them with new ideas and practices:

> Habits such as these are frequently the result of carelessness, and have become habitual and ingrained because they have been handed down for generations among the operative classes, and they are consequently very difficult to break off or eradicate; and for the real and permanent cure we must look to the rising generation, the children of to-day, who in a few short years will be the men and women of the town (Pilkington 1902:283).

The children of this generation would, "... be the fathers and the mothers of the children who will make this country what it always has been and, I trust, always will be " (Londonderry

1905:22). The education of the rising generation offered the possibility of creating a self-perpetuating family tradition[28].

A. The Children of the State

The programme for the improvement of child health tended towards the nationalisation of children. For this reason, attempts were made to strictly delimit the area of state responsibility for children. This was a contradictory exercise, as will be discussed below. Even with these limits, child health promotion did represent a clear and self-conscious attempt to increase state responsibility for social reproduction.

The assumption of responsibility for children was linked to the conception that they were assets of the state. The aim was to:

> ...reach each member of the community at an early period, and, by advice and assistance, relieve or remove immediate distress and suffering, prevent or modify errors and defects which would probably handicap the individual in the struggle for existence, and diminish his usefulness as an asset of the state, if they did not, as so frequently happens, leave him a burden on the community (Lauder 1908:91-2).

The state had a unique duty to children where parents failed:

> It is to be remembered that the infant has demands not only on its parent, but also on the state by virtue of right; and in measure as its parents fail, either intentionally or because they do not know any better, so it becomes the duty of the State, and in part of the more enlightened members of the community individually, to take the place of the parents, and to make up to the child what it has lost by their deficiencies (Moore 1906:21, emphasis original).

This unique state responsibility for children had to do with their future contribution as well as their vulnerability. Barr

(1907:516-17), for example, wrote that it would be better to spend money on the next generation than on pensions.

> ...if I cease to be of any physical or intellectual value, I cease to be of any value to the State, and the prolongation of my existence becomes a purely personal matter between me and my relatives.

In Barr's view, it made no sense to invest state money in people who would no longer be productive. Children, on the other hand, were the rising productive generation:

> It is the business of the state to look after the health of the mothers and children, and to see that there is no depreciation in the valuable assets of the nation (ibid).

This state responsibility was not seen as an alternative to parental care. Barr, as others "...would make parents do their duty as far as they were able..." (ibid). However, state action was required in situations where the parents could not or would not provide. The failure to care for children would mean both the creation of future pauper dependents and the sapping of industrial might[29].

> The aftermath of our neglect is the crowding of our hospitals and infirmaries, and the enormous consequent increase of expense to the nation, much of which, I believe, could be saved if we only adopted reasonable measures on the lines I have indicated. We are losers also in consequence of the resulting lack of stamina and the limitation of strength in our industrial and commercial workers, which decreases the productiveness of our industries (Kekewich 1904:470).

This increase in state responsibility was particularly important in order to raise health standards among the children of the working class. Existing institutions (such as private schools) helped establish such standards among the bourgeois classes. These standards had to be generalised:

> Waterloo was won in the playing-fields of Eton; the great commercial battle of the future is to be won by adjusting the relations of the child to the state, and the doctor is the person who can best influence public opinion until the physique obtained in the Eton playing-fields becomes common to every elementary school (Collins 1902:601).

The elementary school was to be the ground on which to battle for the health of the future working class. It was here one found "...those who cannot receive instruction except at the public expense...the youngest and poorest of our children, whose health should be our chief care" (Boulnois 1904:367).

The focus of the concern about children, as with public health generally, was the working class:

> The main concern in the past was to make fine men of the gentle classes of the community while the proletariat has had to fend for itself...[today] certain selected classes are well enough provided for, and what we have got to do is devote our energies to the amelioration of the masses (Legge 1904:949).

The children of the bourgeois classes absorbed hygiene from their home environments, in contrast with those from working class families:

> It may also be fairly said that children brought up amidst surroundings which are, on the whole, sanitary, learn instinctively to avoid things to which some of their less fortunate brethren are only too well accustomed (Rucker 1905:8).

These working class children did not primarily need book knowledge, but good practical skills, self-discipline, and decent physical health. Public health programmes oriented to children concentrated on the development of these.

B. Education for Health

The formation of a healthy rising generation required a combination of physical and mental improvement. The kind of education traditionally associated with schools was not a high priority. It was character rather than intelligence that counted:

> From the point of view of national efficiency, character is more important than intelligence. The world is so correlated that a nation without much originality can assimilate the inventions and resources of civilization; but character cannot thus be assumed by imitation. The will in its essence is a quality of muscle (Cockburn 1905:80).

This conception of character was connected to the idea of practical education, a priority within the broader social refrom movement of the time. The formation of health and character, of 'sanitary conscience', at the elementary school level would have an impact far into the future:

> Thus the teachers will carry the atmosphere of practical learning into the schools to develop the sanitary conscience that we want for future generations, to create sanitary homes all over the country, resulting in the standards of the people and the units of the nation being improved (Kerr in Sherrington 1903:36).

The transmission of ideas alone would not suffice for this task:

> Until the national system includes attention to the physical as well as the mental, no great advantage can be expected, and unless some means are arranged by which the school child is ensured nourishment for the body, it is useless to provide food for the mind (Boulnois 1904:356).

It was not just nourishment for the body, but all-round physical preparation that concerned public health officials.

This went under the rubric of physical education, broadly defined. McMillan described the aims of physical education as:

> ...the physical salvation of the whole race through the inculcation from infancy of good habits formed in the love of personal purity, and fixed by the law of social conscience (McMillan 1905:40).

Physical education included a whole range of activities to improve the health of children.

> ...physical education is by no means synonymous with physical training or physical exercises, but comprises the whole of the physical 'bringing up' of our children. It includes the conditions under which the children live, both at school and at home (KeKewich 1904:462).

In school, drills of various kinds were to play a major role in physical education. These drills promised not only physical but also mental development.

> But discipline, prompt and unquestioning obedience to command, is perhaps the greatest gain derived from class drilling;...We may say then that the effect upon the mind of class drilling is the cultivation of will, observation, discrimination, memory, and, above all discipline (self control), without which no character is complete (Sully 1905:30).

Physical education was at the centre of an education oriented to utility:

> We should not lose sight of the fact that education should develop and fit the child to lead a useful life, and not merely to develop its intellectual capacity (Londonderry 1905:21).

The emphasis was to be not only on directly useful subject matter, but also on practical methods of instruction:

> The Hygiene reader should seldom if ever be used, but the children should actually learn to carry out many ordinary habits of cleanliness, and so forth, as part of their school routine (UK.Bd of Ed 1910:237).

The nation needed a working class mentally and physically prepared for its tasks in life. "The system of preparing them for occupations they are likely to have in after-life seems so suitable and excellent" (Boulnois 1904:357). This required a sexual division of education, consciously reproducing the division of labour in society. Girls were to be prepared for domestic labour (the primary concern of public health) and boys for paid work and war (generally outside the purview of public health).

Girls needed to be prepared for their adult life, which would generally include child care:

> We ought, after all, to remember that some two-thirds of the girls in our schools will probably have children of their own; and therefore such knowledge, viz., that of the preparation of food, the simple laws of health, and the acquisition of regular habits, must now be provided for by the state in school (Londonderry 1905:21).

Girls at school were to be prepared in a practical manner for the range of activities involved in domestic labour, with a particular stress on motherhood.

> Elementary hygiene, domestic duties, marketing, cooking, thrift, orderly methods, needlework, the care, the feeding,the clothing, and domestic hygiene of infants should be practically taught to every schoolgirl (Carpenter 1906:137).

Traditional education, concentrating on the development of the intellect, was not of much use as preparation for domestic labour. In fact, it could even be seen as dangerous:

> This system is, in my opinion, most detrimental to the health of girls, who are very hard and keen workers at school. The energy expended in the higher education renders them less able to bear the strain of duty in after-life, more especially with reference to the all-important function of maternity (Carmicheal 1906:432).

Not all officials would have subscribed to this view of women and education, but there was general agreement regarding the author's general conclusion.

> If my arguments be admitted as sound, it will be at once seen how necessary it is, instead of approximating the training of girls to the system adopted for boys, to lay down special rules for their education. To my mind, the hygienic training of girls should be primary, the intellectual of secondary importance (Carmicheal 1906:433).

It was not only training in hygiene that was important for women. Physical education was also important. As with boys, body and mind were both to be prepared for the tasks ahead. The physical education of women had been neglected.

> ...yet from the national standpoint, the healthy development of women and girls is perhaps even more important than that of men. On them devolves the duty of producing and rearing a strong and healthy race (UK.Bd of Ed 1909:182-3).

The need to physically educate girls was used as an argument against the wide-scale adoption of military drill in schools. "The system is not well adapted for girls, and yet the motherhood of a nation is not less important than its fatherhood" (Andrew 1904:82).

The domestic and physical education of girls in school was not seen as an alternative to the instruction of mothers through such methods as home-visiting. Gaffikin (1908:221) emphasised, "...it is useless to attempt to teach a girl of the present

school age such lessons on this subject as she requires to learn."

The predominant emphasis in domestic education was the preparation of girls for work in the home, and particularly motherhood. There were also some who included boys in some sort of preparation for parenting:

> We have, in the past, given girls and boys so wretchedly inadequate a training for home duties that we have not made them capable of looking after the health of their own children (Marvin 1905:70).

Practical education for boys meant preparation for the responsibilities of family life as well as for work and war.

> ... boys should be trained in all the essentials that produce good citizens and good fathers - respect for parents, cultivation of the natural affections, the love of home and country, duty to one's neighbour, personal cleanliness, obedience and decent behaviour, and the leading of well-regulated healthful lives (Carpenter 1906:137).

However, the emphasis in the education of girls was preparation for domestic labour, while boys were to be fitted for wage-labour and military service. The orientation of this preparation for boys was to be general, developing habits, attitudes and physiques rather than specific skills. This is shown, for example, in a debate on the value of military drill in schools. Some argued that military drill in the schools was the best option to prepare the armed forces of the future.

> If every boy in the country were thoroughly and consistently drilled and trained in military exercises from the time he was ten or eleven years of age until his fifteenth or sixteenth year, he would have acquired a sufficient grounding in military knowledge and in habits of discipline to enable him without difficulty at any period of his later career to take up the onus and responsibilities of military services (Robertson 1904:78).

This was disputed by others who argued that an all-round formation was more important than specific military drill. Andrews (1904:83) cited the motto of the Gymnastic Union of France, from General Chanzy: "Faites-nous des hommes, nous en ferons des soldats." This view was shared by Newman: "The two-fold contribution from the schools of a State to its Army should be strict discipline coupled with a healthy physique" (UK.Bd of Ed 1909:183).

In the business of making men, the development of discipline and strength were key priorities. These would serve well in work or war. At the same time, technical education programmes equipping boys for industrial work were being developed by educational authorities. These, however, fell outside of the domain of public health.

C. Practical Ameliorative Work

Public health officials called for changes in the educational content of school programmes, as discussed above. The work of public health in the schools went beyond such advocacy. The medical inspection of students brought public health into direct contact with every child in the school system.

1. History

Medical inspection developed in slightly different ways in a number of countries in the later nineteenth century. Newman traced the modern conception of medical inspection back to the report of Norway's School Commission on school hygiene in 1865-66. The early focus of medical inspection was on "...the material conditions under which the child was taught and upon the school premises and equipment" (UK. Bd of Ed 1908:2-3).

Medical inspection was first introduced in Britain in the 1890's, through a few local initiatives. The first school medical officers in England were appointed in 1890 (London) and 1893 (Bradford) (ibid:4). From there, the spread was gradual until national legislation was introduced in 1907. It was only in the early 1900's that a real focus on school medical inspection developed in the public health literature. As one article stated in 1904:

> The question of the universal inspection of State schools and school children, by specially appointed medical officers, is one that is only beginning to be discussed seriously in Britain (McGregor 1904:412).

In the period leading up to the Education (Administrative Provisions) Act of 1907 there was a flurry of discussion of medical inspection. The ICPD (1904:64-5) called for "a much more complete system of Medical Inspection in schools", one which would be "imposed on every school authority."

In this period medical inspection was seen as serving two related but distinct aims. These were to provide a survey of the state of national health as the basis for longer term research and policy-formation, and to secure immediate improvements in the health of children through encouraging the treatment of ailments discovered. The actual development of medical inspection in Britain was towards the latter, a stress on obtaining actual improvements.

The view of medical inspection as a survey of national health stemmed from military and eugenic sources. From the military point of view the only national survey of fitness occurred in times of war through recruitment or conscription[30]. In the absence of ongoing conscription, however, this military survey was inadequate.

> In a country without compulsory military service the period of school life offers the state its only opportunity for taking stock of the physique of the whole population and securing to its profit the conditions most favourable to healthy development (ICPD 1904:59).

This perspective led to a stress on medical inspection as scientific survey.

> For the conception of physical inspection of school children which I wish to convey to you is that of a national stock-taking by which the unfit shall be selected for special treatment (Chalmers 1905:64).

This survey was to yield crucial data, in a period in which public health "...seems to be at the threshold of an investigation which may in time afford a key to many of the most profound social problems which await solution" (ibid). The problem at this juncture was a shortage of information.

> Our ascertained data are few, and this statement is probably more true of the medical data than of others. The danger is that of generalising from scattered observations, and of attempting to deal with the subject by compartments (ibid).

This national stock taking was particularly important from a eugenic viewpoint. Medical inspection could be seen as a large scale anthropometric[31] survey of physical and mental qualities. Such a survey could replace impressionistic squabbling about the state of the nation's health with hard quantification:

> These [measurements] will sufficiently define his bodily proportions, his massiveness, strength, agility, keenness of sense, energy, health, intellectual capacity and mental character, and will substitute concise and exact numerical values for verbose and disputable estimates (Galton 1906:93).

In the event, however, data collection was a decidedly marginal focus in British school medical inspection. The emphasis instead was on securing immediate improvements in health.

> Emphasis has often been laid by the Board [of Education] on the fact that medical inspection has been instituted primarily in order to obtain practical ameliorative results, the making of a catalogue of defects and the compilation of statistics, valuable as they are in themselves and useful as forming a basis for further action , being, in comparison, of secondary importance (UK.Bd of Ed 1909:74).

The practical ameliorative results sought were not limited to immediate questions of health. The inspection provided an

opportunity for offering parents advice about a range of issues loosely subsumed under the category 'hygiene' (see Newman on 'helpful advice', next page). It also created the occasion for an all-out assault for cleanliness.

> The education, however, of a child has seriously failed in its objective if it has not engendered a habit of cleanliness, one of the most important agencies in fostering the feeling of self-respect (UK.Bd of Ed 1908:46).

One year later, Newman could report that with regard to cleanliness, "...an appreciable improvement has already been brought about" (ibid 1909:28). Medical inspection focussed around a broader range of hygiene issues than just the presence or absence of specific forms of disease.

There were only two ways in which medical inspection could produce practical ameliorative results. First, a school-family link had to be established so that the results of medical inspection could be communicated with recommendations for action to parents. Secondly, identified needs could be met through direct provision in the schools, primarily of medical treatment and meals.

ii. The School-Family Link

Medical inspection in schools faced the daunting task of attempting to improve children without in any way undercutting the moral and material autonomy of the family. The best way to do this was to involve the parents, so that the discovery of defects in the children was at the same time a means of parental education.

The most direct way to involve the parents was to secure their presence at the inspection. Newman strongly favoured the presence of parents at medical inspections.

> The work of medical inspection is essentially of a preventive nature, and in a large number of instances there are matters to which the doctor may usefully draw the attention of the parent, and yet which would not lend themselves to expression in the form of a notice transmitted through the post (UK.Bd of Ed 1909:74-5).

These matters to which the doctor might draw the parent's attention went well beyond immediate medical concerns.

> In many cases helpful advice may be given in regard to matters of hygiene, the feeding and clothing of the child, the need for and adequate amount of sleep or for the efficient ventilation of the bedroom or even the future occupation of elder boys and girls (ibid).

The proportion of parents attending medical inspection varied widely, from around 14% in Stockport to 83% in Birmingham (ibid). Newman saw the higher proportions as an inspiration to increase the efforts of other areas in this direction. The inclusion of parents in medical inspection meant that rather than undermining parental responsibility, the inspection was building it.

> The fear at one time expressed that medical inspection might tend to undermine the responsibility of the family has not only proved to have no foundation in fact, but it is hardly too much to claim that medical inspection has been directly instrumental in bringing about an awakening and development of the feeling of responsibility in the parent (UK.Bd of Ed 1911:96-7).

Of course, the presence of parents at medical inspection could not always be counted on, even where the authorities exerted pressure. In such cases, "...a corresponding advantage might be obtained by arranging for a health visitor to call on

the parents, to explain and emphasize the medical report" (Wilson 1905:78, see also UK.Bd of Ed 1910:100).

This involvement of parents would increase their responsibility by overcoming ignorance:

> Much of the lack of parental responsibility has been apparent only, and has been due to ignorance, custom and the prevalence of a low standard of personal hygiene both in the school and among the general community (UK.Bd of Ed 1910:108).

However, ignorance wasn't the only obstacle which stood between parents and the appropriate care of their children. Negligence prevented proper care (e.g. Crowley 1909:146). More generally, even parents with the best interests of their children at heart did not necessarily have the resources they needed to care for their children, lacking food, a proper source of water for bathing, etc. The facilities for affordable and accessible medical care were inadequate (e.g. UK.Bd of Ed 1908:33).

In cases of negligence, non-cooperation or lack of resources, no amount of visiting, education, advice or pressure could make parents solve problems in the recommended fashion. The only way to ensure action in these areas was through direct provision by school authorities, either with or without the shifting of costs onto parents.

iii. Direct Provision

Medical inspection systematically identified children's needs; for medical treatment, better feeding, bathing facilities, etc. The most sound method of seeing these needs filled from the

public health perspective was through the parents. Yet the ability of parents to fill these needs depended largely on social class.

> The lifetime of the child may be divided into its hours of home life and of school life. During the former conditions surrounding the child's health depend, of course, largely upon the social class of fortune of the parents (Sherrington 1902:311).

The school, however, could provide a hygienic environment for all.

> Often the child's defence against the unhealthy environment must be far more with his school than with his home - with well-chosen and instructed school teachers, than with ill-instructed or careless parents (Sherrington 1902:312).

Medical inspection necessarily raised the question of the extent to which the school should be used to provide a 'defence against the unhealthy environment'. The provision of bathing facilities to promote cleanliness was not controversial.

> In some districts, however, if the children are to attend school in a clean condition, it would appear to be necessary to supplement the efforts of the home. Experience has shown that, in the larger cities and towns, especially, the condition of the home and the home life, due largely to a somewhat low ideal of hygienic living, do not permit of a high or even a reasonable standard of cleanliness (UK. Bd of Ed 1908:46).

The level of controversy rose, however, in the discussion of medical treatment for ailments discovered during inspection. The Education (Administrative Provisions) Act of 1907 not only laid the basis for a national system of medical inspection, but also opened up the possibility of expanded state medical treatment for

children.

> It [the Act] obliges the local authority to acquaint itself at an early period with the physical, mental and social conditions of practically every child within its district, and foreshadows, in no uncertain manner, the possible obligation that will be considered as necessary for dealing with certain cases, if not the medical treatment of all children who require it (Lauder 1908:92).

Newman called for extreme caution in projecting the expansion of medical inspection into broader services. He announced three principles to a conference on school medical inspection.

> 1. ...our work must of necessity, for some years to come, grow in a very gradual, and perhaps you will think slow, way.
> 2. Medical inspection is not the be-all and end-all.
> 3. ...we must aim, not at the best, but at the best that is practicable (Newman 1909:161, emphasis original).

While central authorities urged caution, at the local level some officials found that inspection without treatment was an inefficient use of funds. The committee overseeing medical inspection in Bradford responded to the demand from the central government for increased inspection by insisting on the development of some treatment provisions:

> ...the committee were very loth to incur this expense unless at the same time steps were taken to ensure treatment, to some extent, at any rate, of the defects and diseases found. Previous experience had convinced them how necessary this step was if the money spent for inspection was to yield a satisfactory return (Crowley 1909:145).

Bradford, a pioneer in the area of medical inspection, was a leader in the introduction of treatment. A clinic was

established in 1908.

> The clinic has been opened for about six months, and its advantages are unquestionable; children get treated who, were it not for the school clinic, would remain untreated- that is the outstanding fact (ibid:146).

This clinic was not to serve as a complete alternative to parental provision, as parents were to be involved:

> ...a notice is given to the parent stating that she must either take the child to a private practitioner, or to one of the hospitals, or to the school clinic...and pressure is brought to bear, and effectively, to ensure one of the above alternatives being carried out (ibid).

The regulation of parents, the enforcement of parental responsibility, was an important part of the clinic programme. Crowley proudly boasted: "The mother has a comparatively poor chance now of neglecting her child" (ibid).

This was an area of some contention. Lyster (1910:190) argued that the Children's Act of 1908, "...provides penalties for the parent or guardian who refuses to obtain treatment for a child." The enforcement of that Act, rather than treatment in the schools, was the best way to ensure that children needs were met:

> ...an Educational Authority, as such, does all that may be expected of it when it discovers and draws attention to the bodily needs of the children, warns and advises the parents, and gives information to those whose business it is to see that the parents' obligations are carried out in one way or another, but not out of educational funds, or under the direction of educationalists (Lyster 1910:190).

Lyster specifically took issue with those who argued that some children could not be educated without medical attention: "The same argument would apply in favour of the educational authority providing sleeping accommodation for those children

needing a good night's sleep" (ibid: 191). Such an extension of direct provision through the schools was seen as absurd[32].

Lyster was not necessarily opposed to free medical treatment, but to the treatment of children through the schools[33].

> If the principle of universal treatment is right then there should be an extension to other ages; if it is wrong, it should be abolished altogether (ibid:198).

In the discussion that followed, many disagreed with Lyster. Stephens argued that "...the state, having paid for the investigation of the defect, should remedy it" (ibid:201). Richards advised authorities "... to do as much as possible in the way of medical treatment at the present moment" (ibid:199). Nash stated that there were few objections to school clinics: "The difficulty with regard to the treatment of school children was the parents who would not do anything" (ibid:200).

The national programme of medical inspection prompted considerable debate and local initiatives with regard to treatment. The official policy of Newman at the Board of Education was to emphasise parental responsibility for treatment, while recognizing the difficulties the issue presented.

> Speaking generally, the duty of medical inspection falls upon the Local Education Authority, the responsibility for treatment of the defective child upon the parent...[However] Here we have, admittedly, a complex problem involving the adequacy of treatment as well as treatment of the necessitous (UK. Bd of Ed 1912:129).

The bridging over from inspection to treatment was soon recognized at the national level, despite the caution expressed above. In August 1913 regulations were introduced which allowed

grants from the Board of Education for treatment as well as inspection (UK. Bd of Ed 1913:13).

The following year the Chief Medical Officer's annual report noted "...the steady increase in the amount of provision for medical treatment by Local Education Authorities..." The major fears concerning such an increase were proving to be unfounded. This increase was not increasing parental irresponsibility, but rather provided a forum for educating parents. It did not create a tremendous burden on ratepayers. Finally, it had not hurt private medical practice (UK Bd of Ed 1914:185-86).

The medical treatment of school children, then, came to be seen as an acceptable form of direct provision when approached cautiously. As with school meals[34], local initiatives demonstrated that direct provision did not pose an immediate threat to family self-reliance, where developed cautiously with maximized parental involvement (personal or at least financial).

The wider acceptance of medical treatment in schools marked an important point in the transition of public health towards medical and economic as opposed to social and moral regulation. Medical inspection was initially conceived in broad social work terms, emphasising the school-family link and the battle against maternal ignorance and neglect. It developed, however, towards the medical treatment of specific illnesses.

State provision was accepted in circumstances where the parents could not provide on their own, or where the need was so pressing that it could not be left to the parents discretion.

Initial fears about undercutting parental responsibility through direct provision seem to have been eased in practice. Yet the domain of direct provision was to remain as small as possible, tiny areas of exception to the rule that parents provide.

D. The School and the Family: Contradictions

The formation of a healthy rising generation through the school system is a specific example of the broad contradictions of regulating the family. Children were at once 'assets of the state' and the responsibility of their parents. Any move to improve the health of the state's assets was a threat to family self-reliance, combining dependence on the wage and unpaid private labour. Similarly, exclusive parental responsibility left the health of the next generation subject to the ability and willingness of parents to provide.

Public health officials were highly cautious about any intervention that threatened parental responsibility. In those exceptional areas where intervention was required, the aim was to strengthen the school-family link. Where possible, parents were to be involved in the process, either personally or financially. Compulsion was to be used in those cases where parents were capable of meeting needs themselves and yet did not (see Kerr 1905:62 and Lyster 1910:195 cited above, p.58).

These measures, however, could not resolve the fundamental contradiction between the private reproduction of the working

class and social production. In order to raise the standards of the next generation beyond a certain point, either the standard of living of the working class (particularly the lower paid sectors) had to be raised, or the school had to be used as the thin end of the wedge of socialised reproduction. Public health officials certainly recognised the problem:

> The problem of the improvement of the physique of the people lies deeper than the school. Decent homes and healthy surroundings, fresh air and sufficient food, are indispensable, if the race is not to deteriorate (Kekewich 1904:463).

There was certainly some concern that schools, as socialised reproduction, deepened the problem by interfering with private reproduction.

> The State takes the child away all day long from its home from three years old upwards, or at all events from five years old, and thus deprives it (and particularly the girls) of the natural means provided by home life of obtaining, even though by rule of thumb, important training in such matters as the preparation of food, the care of children, and simple laws of health (Londonderry 1905:21).

Marvin (1905:70) argued similarly that schools "probably have weakened the maternal instinct" by taking girls out of the home. Yet Marvin herself argued for school nursing:

> It may seem inconsistent with what I have said, about leaving as much as possible to the mother, to propose that these things should be attended to by a nurse. But the object of getting them done by a nurse should be, I think, to teach the mother how to do them. And where the mother is hopelessly negligent and will not do them, it is better that they should be done by a nurse than not at all (ibid:72).

'It is better that they should be done than not at all' summarises the public health position on certain key services. However, in doing so the state was displacing the parent. This

was eased in part by the educational aspect of the programmes, teaching parents and children the skills of self-reproduction through practical experience and expert assistance. Newman, for example, described school meals as themselves "object lessons" (UK.Bd of Ed 1914:220).

However much meals might be described as object lessons, the simple fact remained that school meals provided children with an alternative source of nutrition not dependent on their parents' wages. Newman noted, for example, that school feeding had increased during a major coal strike (UK. Bd of Ed 1912:273). While there was no further comment on this fact in the annual report, it is significant that the children of striking workers were fed by the state. Starving children can be a powerful weapon against strikers, a definite pressure to return to work. Yet starvation also damages the national assets, the future generation.

School programmes could threaten not only the material self-reliance of the family, but also its ideological structure. Family authority structures, for example, were sharply threatened where children were to act as state agents in the education of their parents. "The child will often be the medium in this parental education..." (Kenwood 1905:142).

Despite these problems, the protection of the rising generation was regarded as sufficiently important to warrant regulation. This regulation tended in the direction of

socialised reproduction. The question was how far to go in that direction.

The ICPD (1904:18-19) went very far in its call for an experimental programme to break the poverty cycle by expropriating the family as a last resort in cases of habitual vagrancy. Parents were to be placed in compulsory labour camps, while their children were to be "...lodged in public nurseries until their parents were improved up to the point at which they could resume charge." This experiment might have wider applicability.

> [It might be useful, given]...the interest the community possesses in the preservation of the young from contaminating and depressing influences, to apply similar treatment to the children of all parents who have proved unfit to their obligations to those they bring into the world (ibid).

In such cases, parents were to pay for the upkeep of their children through work in a "labour establishment under state supervision." These harsh measures were to serve as a warning to others:

> ...the fact of a few being so treated experimentally and the knowledge that the state had and might wield such power would exercise a most salutary effect in bringing home to parents the nature and extent of their liabilities, and might be expected to prove to the young a charter of immunity from the most crying evils by which they are at present oppressed (ibid).

This nightmarish vision of socialised reproduction under capitalism provides an example of the extreme case of total expropriation of the family. Such a programme, if instituted, would have been a massive assault on the ideology of privatised reproduction. Even the more moderate measures favoured by some

public health officials went more than a few steps down the road to socialised reproduction.

Some officials, for example, favoured nurseries or creches as a last resort for those mothers who had to work outside the home (see above section 4.2.1.D). This was only acceptable on a limited scale under specific circumstances, so as not to offer an alternative to the home. Certainly it was not seen as a way to systematically address the problem of standards of family care.

> The aid of nurseries and nursery schools is required to meet temporary or local needs, but the way to improve the health of the younger children as a whole is not to take them from their homes and make general institutional provision, no matter how excellent, but rather to educate and assist their mothers to care for them wisely at home (UK.Bd of Ed 1911:231).

Public health sought to establish the regulation of childhood, from the heath visitors, mothers schools and clinics established to oversee infancy to the various programmes operating through the school system. Newman noted that the one gap in these services was children under school age, who should increasingly be drawn into school services (UK.Bd of Ed 1912:337).

This regulation was primarily to be achieved through 'oversight' or 'supervision', through shaping the mother's domestic labour[35]. This was best described by Struthers, a Canadian public health official: "Therefore the state should be the over-parent, and see that the parents properly feed, clothe and care for their children" (Struthers 1914:74). As over-parent, the state could be seen as promoting rather than

undercutting self-reproduction through the family. Even this rubbed against the autonomy of the family.

However, public health could not stop at the role of over-parent. Too many parents simply could not or would not 'properly feed, clothe and care for their children', even under state scrutiny. The protection of the future working class, however, could be secured only at the expense of eroding the self-reliance of the family. The contradiction between social production and private reproduction is both the basis for this public health intervention and the reason for its cautious nature.

4.3 The Regulation of the Family in Britain and Canada

British and Canadian public health shared a similar orientation to the regulation of the family in the period 1900-20. In broad strokes, both stressed the creation of the hygienic home through regimes of home visiting to establish and enforce standards. Both emphasized the formation of a new generation free of ignorance and the taint of degeneration.

The primary difference between the two was that British public health had moved further towards the direct provision of services. In Canada, the emphasis remained primarily on instructional methods, even where programmes such as medical inspection developed. In Britain, national coordinated programmes directly providing goods and services were developed under the auspices of public health, particularly in the areas of school meals and medical treatment.

This section will explain these similarities and differences. It will begin with a sketch of the development of public health programmes oriented to the family in Canada in comparison with the British developments charted above. The structure of Section 4.2 above is repeated here to allow for ease of comparison. The similarities and differences revealed in this comparison will be explained in terms of the development of social policy in the two countries.

4.3.1 The Hygienic Home

In Canada as in Britain, public health activity to standardise working class life focussed primarily on the hygienic home and the next generation. These were the strategic points in the battle against ignorance and demoralisation. The aim was to establish the healthy working class family as the self-perpetuation basis for national health.

Eunice Dyke (1913:403), the head of public health nursing in Toronto, wrote: "The unit in health work is the family, not the individual." The crucial foundation of the healthy family was the hygienic home.

> ...the unit of the town or city is the home; and, as we each make our home and its environment healthy, we are each doing our bit to improve the health of the community in which we live and the country generally (Conservation of Life 1919c:25).

As in Britain, the conception of the healthy home environment in this period had changed from that of the old sanitarianism to that of the new hygiene. Sanitarianism in its pure form had not been fully established in Canada as a result of the later development of public health. Nevertheless, officials saw themselves as making a transition from a focus on the built environment to an emphasis on the social environment, meaning the knowledge, skills, habits and attitudes of family members, particularly women.

> The essential change is this, the old public health was concerned with the environment; the new is concerned with the individual. The old sought the sources of infection in the surroundings of man; the new finds them in many cases in himself (Hill 1912:138).

In fact, the old sanitarian concerns were sometimes dismissed. Hill (ibid:139) wrote of the environmental concerns of the earlier generation, "But these conditions cannot induce infection, nor will the converse conditions ward it off..." Hastings (1917:53) wrote that garbage, plumbing and drains remained as health issues primarily for, "... comfort and convenience, and the moral effect from the standpoint of cleanliness..."

> ...the activities of a modern department of health are vastly different from what they were a few years ago, when they were bending all their energies to the abating of nuisances, the collection and disposal of garbage, the cleaning of the streets, back-yards and lanes. These activities are essential in any self-respecting city, but it would be difficult to demonstrate that their neglect would be responsible for one single death (Hastings quoted in Smith 1924:58).

The basic direction for the regulation of the family derived from the theory and practice of the new hygiene in Canada as in Britain. A combination of environmentalist theories of degeneration and germ theories of disease underpinned an approach to raising health standards which stressed education.

> It is sanitary instruction and not sanitary inspection that must necessarily constitute the true foundation of public health (Hastings 1917:89).

This sanitary instruction had two objectives. It aimed first to regulate the domestic labour of women, the basis of home life. Secondly, it aimed to establish standards of physical, mental and moral hygiene for the next generation, both through regulating parents and directly through the schools.

A. Domestic Labour and Home Visiting

The new public health in Canada as in Britain aimed to improve the social environment of the home through establishing standards for the domestic labour of the home-maker. These standards were to be established in two ways. Some programmes were introduced which brought home-makers out of the atomised setting of the private home into special collective situations, including courses and lectures, well baby clinics, cooking lessons, health exhibitions, etc. More importantly, home visiting programmes combined education and inspection right in the home.

> The greatest amount of betterment could be accomplished probably by regular and systematic instruction in the homes on the care and feeding of infants; cleanliness and general sanitation; the handling of infectious diseases, etc; by women health visitors, trained and specially adapted for such work (Roberts 1912:182).

In Canada, home visiting was done primarily by public health nurses. Public health nursing had three roots: home care nursing, child welfare nursing and school nursing. The first was treatment-oriented home care nursing, as practiced by the Victorian Order of Nurses, which involved regular visits to sick people organised on a district basis (Andrews 1979:144).

When home care nursing was adapted specifically to tuberculosis in the early 1900's the emphasis shifted from treatment to education in hygiene and healthy living. The aim was to replace sanatorium treatment with home care which could minimize the threat of spread of disease and encourage the

healthy living regimen seen at the time as curative, including fresh air and sunshine (Royce 1983:20-22).

This change in the character of home care nursing derived from the changing conception of tuberculosis as a disease. The old belief was that it was "...a hereditary disease and practically 'hopeless...'" (Adami 1912a:332). The new was that tuberculosis was a disease which spread in unhygienic and unhealthy living conditions; which could be prevented through hygiene and treated through fresh air and sunshine. As Bryce (1918:16) wrote in his article entitled 'Tuberculosis: A Disease of Insanitary Living.':

> Education of the individual stands in the first place in the measures for the prevention of tuberculosis, and all persons whether physicians or members of families where the sick are, should teach and be taught the principles of personal hygiene.

It was, therefore, a small shift from the mandate of the tuberculosis nurse to that of more generalised hygienic instruction and inspection[36]. Similarly, the mandate of child welfare nurses was prone to generalisation. Child welfare nurses were employed first in Toronto by settlement houses (from 1907 on) and then by the city (after 1912) (Royce 1983:46).

Child welfare work in Toronto began with clinics, mothercraft classes and creche inspections (Brittain 1915:366). The focus of work changed from trying to draw mothers out to classes, etc. to visiting the home. Sutherland (1976:60-2) traced a child welfare campaign in Hamilton from a clean milk depot to a clinic to a centre organizing home visits. The next

step was to begin actively searching out clients using improved birth registration etc (ibid:64). This is not to imply that clinics, etc. were completely replaced by home visits, but that home visits became increasingly central.

School nursing also generalised easily towards public health nursing. The emphasis in school medical inspection moved from inspection for contagious diseases conducted by doctors to home visits conducted by nurses (e.g. Sutherland 1981:379-81). The head of medical inspection in Toronto schools wrote:

> The great aim of medical inspection of schools should be preventive medicine, not curative. Treatment or procuring treatment must necessarily be a part, but education constantly teaching the laws of health should be our greatest work (Struthers 1913:68).

A year later, he described the duties of school nurses and medical inspectors in broad terms:

> The medical inspector and nurses of each district are expected to have an accurate knowledge of the prevalence of disease, sanitary conditions, home environments and cleanliness, and the number of indigent families in their districts (Struthers 1914:67).

In short, tuberculosis nursing, child welfare nursing and school nursing converged so that each involved a combination of home instruction and inspection. In Toronto, this convergence was recognized organisationally with the merger of tuberculosis and child welfare nursing (1914) and the addition of school nursing (1916) into an integrated programme of generalised public health nursing (Smith 1924:58, Brittain 1915:368). Even where this kind of organisational merger was not undertaken, there was a methodological convergence towards public health nursing

concentrating on the promotion of domestic hygiene. These public health nursing programmes grew rapidly; most dramatically in Toronto where the increase was from two in 1910 (one tuberculosis nurse, one school nurse)to over 50 in 1915 to 114 in 1924 (Smith 1924:45,58; Brittain 1915:368; Struthers 1914:67).

Public health home visiting, then, had slightly different origins in Canada and Britain. In Canada, a specific medical discipline (nursing) developed a branch which moved towards a concentration on domestic hygiene. In Britain, a philanthropic endeavour emphasising domestic skills was upgraded and professionalised to serve as a vehicle for scientific hygiene. In both countries, it was regarded as fundamental that these visitors dealing with domestic labour would be women.

There was some variation in the specific aims of home visiting programmes. All, however, tended to emphasize improved domestic efficiency around the related areas of household hygiene and child-rearing. The convergence of public health nursing (in Canada and the United States) and health visiting (in Britain) represented the adaptation of existing resources to meet the goals of the new hygiene in the standardisation of domestic life.

B. The Method of Standardisation

The basic methods used to establish hygienic standards for domestic labour were similar in Canada and Britain. This similarity derived from the requirement that regulatory methods be compatible with the privatised nature of the domestic labour

process. In both countries, particular diseases and conditions were used as calling cards by visitors who attempted to win the confidence of the home-maker but were ultimately backed by the possible use of compulsion.

The calling cards used in Canada were basically the same as those used in Britain. Public health nurses did home visits mainly on the basis of the birth of children, illness at school, cases of tuberculosis and venereal diseases. Smith (1924:58) described one aspect of the work of Toronto public health nurses as, "...following up the many clues that come from clinics, birth registrations, schools and the social agencies."

Specific diseases or conditions directed home visitors towards those households where hygiene was most likely problematic. As well, the use of a specific health concern as a calling card generally eased access to the private domain of the home. L. Struthers (1917:71) wrote with regard to the school nurse, "If she is able to say that she called because she heard Johnny was sick, this generally paves the way for a cordial understanding."

The use of specific calling cards did not solve all the problems of access to the private domain of the home. The regulation of domestic labour from the outside required tremendous tact, as the aim was to win the mother to higher

standards by conviction.

> The trained, and let us add, the kindly and diplomatic nurse, became the guide, philosopher and friend of the family. The school nurse who fails to get into intimate touch with the family must confess she has failed in her first mission (ibid:8).

It was a question of delicately balancing instruction and pressure. Dyke (1913:403) wrote that the public health nurse must, "...be able to utilize authority in the home when necessary." Public health officials certainly had no principled objection to compulsion:

> ...in the interest of public health, which means national efficiency, it will be necessary to continue at times to compel the individual to do for the benefit of others what he may not wish to do and that for which he sees neither the need nor the logic (Wesbrook 1912:491).

In the home, however, this compulsion had to take a special form. This was due, in part, to the moral autonomy of the home. It was also due to the impossibility of regular supervision (as in a workplace) meaning that the internalization of standards was the only way to ensure lasting changes. L. Struthers (1917:71) wrote that if the visitor came "as one wielding authority that must be obeyed, she will always fail to gain the best cooperation, though she may gain her point."

Instead, the aim was to obtain voluntary co-operation. Struthers went on to describe the tact required in obtaining this

cooperation:

> Not infrequently the parents are prejudiced against the nurse before they ever see her, for they conceive the idea that she is interfering with their authority over their children. Some will receive her cordially, while others will pour a tirade of abuse upon her unlucky head...but like a skillful general, she will retreat or advance, outflank or make a frontal attack, until the parents capitulate (ibid).

This method of moral suasion remained central to public health home visiting in this period in Canada and Britain. The only important difference was that in Britain, this suasion was at least supplemented and perhaps even replaced in some cases by the development of definite services on a free, accessible and at times compulsory basis. Canadian officials had little to offer except guidance and moral authority in a period where their British equivalents were able to provide access to a limited but important range of services including school meals and medical treatment.

C. The Moral Standards of Domestic Hygiene

A central task for household hygiene in Canada and Britain was to establish scientific standards for women's domestic labour. These touched on many areas of domestic life. The object of these standards was to improve physical mental and moral health through promoting healthy life habits, preventing disease, and raising the moral level of the home.

In Canada and Britain, the scientific claims for these standards was rooted in germ theory. Interpreted narrowly, germ theory reduced the parameters of public health to identifying the

infected individuals and preventing the spread of germs from them to others who were not infected (Hill 1912:139). This narrow interpretation would emerge as dominant in public health as the shift was made from social/moral to medical/economic regulation after 1920. A new medically-oriented public health practice would develop which concentrated on eliminating contact cases and preventing the transportation of germs through food, water, insects, etc.

In this period, however, germ theory in both Canada and Britain was linked to a broader theory of social hygiene. The core of the theory of hygiene was a moral code stressing discipline, temperance and order. W.Struthers (1914:78), for example, described the school nurse as one who "...advised, directed and brought order out of untidiness, uncleanliness, discouragement and distress."

This disciplined domestic order had a number of dimensions. Struthers (1914:68-75) discussed the full range of activities in school medical inspection, which included: hygiene education; nutritional education; elimination of childhood coffee drinking; teaching proper sleeping habits; advocacy regarding recreation, clothing and footwear, and general cleanliness; nose blowing drill, segregation of the feebleminded and instruction on sex hygiene. This was not simply a question of reducing the risks of germ transmission.

The establishment of a regime of disciplined self-regulation was central to public health home visiting in Britain

and in Canada. The character of this regime was similar in both of these countries on the basis of the identical character of the domestic labour process. The transition towards economic and medical forms which would eventually displace this moral regime from the state regulation of domestic life had not yet begun to leave its mark in this area in either Britain or Canada.

D. The Sexual Division of Labour

The reinforcement of the sexual division of nature was regarded as a crucial aspect of the regulation of domestic labour in both Canada and Britain. The sexual division of labour was integrated into public health theory, so that officials advocated minimising paid employment for women (particularly mothers)[37] and maximising their domestic efficiency. As Plumptre (1914:28) wrote, "The conservation of human life is the immediate duty of the women of this country..." The key was to equip women to carry out their duty more effectively.

Canadian officials tended to demonstrate the same commitment as their British equivalents to preservation and reinforcement of this sexual division of labour as a necessary condition for the improvement of domestic labour. In Britain, however, a current emerged which regarded the paid employment of women as an economic necessity and sought to provide services to working women which to a limited degree socialised domestic labour (creches, cheap restaurants) (see above, section 4.2.1.D). I

have seen no evidence of such a current in Canadian public health[38].

This difference was related to a changing conception of the working class problem in Britain linked to the shift towards economic and medical regulation. While the paid employment of women was seen as both cause and result of demoralization, then the remedy would consist largely of moral suasion not to work outside the home. If women's paid employment were connected to economic conditions then regulation would take such forms as through such means as benefits (paid maternity leave), services (creches) and medical care. In British public health, unlike Canadian, there were glimmerings of the latter view of women's paid employment in this period.

This is not to imply that the economic conception of women's paid employment became dominant in Canada and Britain in the same way that economic and medical forms of social policy did. British and Canadian states have tacked between moral and economic conceptions of the paid employment of women and the sexual division of labour through the twentieth century, driven by the contradiction between the drive for women's participation in social labour and the need to 'free up' women's time for domestic labour.

4.3.2. The Next Generation

Canadian and British public health both aimed to promote immediate changes in the standards of working class life through the introduction of domestic discipline. This was to be accomplished through both a regime of home visits and through programmes aimed at the next generation. It was the latter that tended to inspire the most optimism among officials in both countries. As the MOH of Hamilton, Ontario wrote: "Our chiefest concern is with the children, the rising generation" (Roberts 1912:182).

An intervention around the next generation had three major benefits. First, the young were susceptible to new influences. They were not yet ruined physically, mentally or morally to the extent of their only somewhat salvageable parents.

> It is easier to influence the open mind of a growing individual to recognize the defects of old habits and methods and to carry out what reason tells them is a right and acceptable mode of action, than it is to persuade the adult, hardened by custom (Adam: 1912:372-4).

Secondly, the children provided another route of access to families. This route was advantageous both because children were more open and because they were brought together in schools creating the opportunity for collective as opposed to individual education[39].

> ...[the child] talks over the matters at home, and time and again his lively enthusiasm for what is obviously right and reasonable, as opposed to the old-time and wrong method, impresses the needed change in home conditions (Adam: 1912:374, see also Laurie 1913:456).

Thirdly, the emphasis on the next generation represented an investment in the future, a longer term approach. This worked in two ways. It meant that resources would be aimed where they would have the greatest impact on the shape of future workers. As well, changes achieved in the standards and attitudes of the young promised to be self-perpetuating as these in turn raised their own families.

The emphasis on the next generation was found in many areas of public health work. Even in the area of sexually transmitted diseases, Smythe (1918:69) wrote: "it is generally agreed that education should begin with the young."

A. The Children of the State

Canadian and British public health officials saw the formation of the next generation as the responsibility of the state. Yet this view collided with the moral and material autonomy of the family. In fact, public health officials attempted to promote both state guardianship and sole parental responsibility. This seemingly irresolvable contradiction was sidestepped by focussing state guardianship primarily on the parents, to enforce sole responsibility.

The enforcement of parental responsibility was not adequate in itself. In Britain, a limited degree of direct provision began to develop around the periphery of parental responsibility, operating mainly through the school system. In Canada, such direct provision developed only in limited and localised forms.

The enforcement of parental responsibility for the children of the state remained primary.

W. Struthers (1913:68) exemplified the public health view of children as a state responsibility in a complaint against politicians who were willing to exercise a degree of guardianship over natural but not human resources.

> Politicians, however, forget the children of the state, or are not seized with the importance of their health, nor do they seem to realize that the greatest asset of the state is the children (see also Barr 1907:517, Brown 1918:145).

The state responsibility for children was to be exercised indirectly through supervising the activity of parents.

> All parents should be held strictly accountable for the health of their children. It is as important to the nation as it is to the individual (L. Struthers 1917:4).

This role of the state in holding parents accountable was described by the Chief Medical Inspector of the Toronto Board of Education in the following terms: "Therefore the state should be the over-parent, and see that the parents properly feed, clothe and care for their children" (W. Struthers 1914:74).

There were, however, limits on this relationship; cases where parents either could not (due to material poverty) or would not (due to moral poverty) provide for their children. In those cases where parental responsibility could not be enforced, British public health was in the forefront in the development of programmes of direct provision for the children of the state. In Canada, the responsibility for the state's children continued to be exercised almost entirely through indirect means, that is through state activity as 'overparent'.

B. Education for Health

Canadian public health officials aimed to shape a new generation largely free of ignorance and demoralisation. This was to be accomplished largely through the supervision of parenting. Health education through the schools was another way of reaching this goal without coming into conflict with parental responsibility.

One of the areas of health education which was stressed in Canadian public health was the instruction of girls in the skills of motherhood. Mothercraft had to be raised from an instinct to a skill, properly taught in a scientific manner.

> In modern life mother instinct is an inadequate guide for the rearing of children into capable men and women. The mother needs the assistance of those with special knowledge and teaching aptitudes (Struthers 1917:259).

The school presented an ideal opportunity for training the next generation of mothers. Not only was this a good idea for the future, but also a practical and immediate necessity. Many young girls were already taking responsibilities for younger siblings. Struthers (1917:117) wrote that it was a common sight to see young girls in charge of babies, "...while the mothers are out working or busy with household duties."

One response to this problem in Canada was the establishment of Little Mothers classes which aimed to equip young girls to care for their siblings. These classes could at once deal with the immediate problem and provide a sound foundation for motherhood in the future. Little Mothers classes were developed

after efforts to change the situation through educating mothers failed:

> After many efforts in many directions to help the overburdened or careless mothers to look after these neglected children, a solution of the problem was found by the school nurse in the formation of the Little Mothers classes in the schools (ibid:118).

The young girls in these classes were taught hygiene, feeding, etc. At first, the membership in these classes was restricted by age (over 12 years) and one other important criterion:

> ...each girl must be able to bring a baby to the lesson when required. In this way the 'little mother' is given an opportunity to demonstrate the lesson taught on her own charge whether that lesson was washing, drying, dressing, or feeding the baby or cleaning baby's feeding bottle (ibid:119).

These classes taught a wide range of motherhood skills. They soon proved to be so popular that they were opened up, at first to anyone who could borrow a baby, and then to any girl over 10 years old (ibid:120). These girls were encouraged not only to care for babies in their family, but to perform good acts for others.

> Such acts of kindness as warning a mother about the danger of a comfort; taking a child into the park for air and sunlight, making netting to protect the baby's eyes; instructing a mother how to keep the milk clean and cool, are some of the suggestions that may be made when organizing the class (ibid:122).

The 'little mothers' were practitioners and missionaries of hygienic living. The school was an atmosphere in which training for motherhood could be collectivised and rehearsed under direct supervision, in contrast to the conditions of domestic labour in

the home. The problem was the unreality of the school setting, overcome perhaps by the use (in the early period of Little Mother's Classes) of real babies.

Training for motherhood was just one aspect of health education aimed at the rising generation through the schools. Canadian officials in this period heavily stressed hygiene education. This involved more than teaching children to wash their hands before dinner. Public health was part of a broader movement towards practical education[40] for working class children in the early 1900's. Struthers (1914:74), the medical officer to the Toronto Board of Education, epitomised the public health view of education:

> It is more deeply realized every day that the whole function of the Public School, primary and secondary, is to fit the child physically, mentally and morally for its place in the State, to develop its body as well as its mind so that it may become an efficient member of the community.

Hygiene education had an important part to play in reaching this goal. As Struthers (1914:74) wrote, "Clean and right life habits will mean more for a child in life than a smattering knowledge of art and music."

The key themes expressed in hygiene education seemed to have been cleanliness, discipline and rectitude. In each of these areas the aim was to combine improvements in physical health with moral elevation. This was certainly true of cleanliness, as shown by this statement by Struthers (1914:72) regarding showers at school.

> Nor need I tell you how much a child's self-respect is increased, its moral tone uplifted, its health and general

> welfare improved by being kept clean and sweet and wholesome.

Discipline concentrated on the development of regular habits around many areas of life, from bodily functions to sleep and work. A book aimed at schoolchildren written by the medical officer of the Toronto Board of Education and a high school principal advised:

> Regular habits are essential to good health, especially in eating, sleeping, and the daily action of the bowels which must always be attended to immediately before or after breakfast every morning (MacMurchy and Auden 1911:6)[41].

This discipline focussed around work as well as domestic tasks: "Put in a good day's work every working day. Every part of the body and mind benefits by good work" (ibid:9). A regular daily routine was recommended, including fixed times for meals and homework (ibid:6). The internalization of standards of self-discipline, justified on health grounds, was a major focus of public health in this period[42]. "In the development of character children must learn the importance of discipline and more especially of self-discipline" (L. Struthers 1917:261-2).

Attempts were made to teach rectitude, moral standards for certain areas of life. This was an area for some delicacy, as morals education was regarded as the domain of the family and its chosen spiritual institutions. This did not mean that public health should disqualify itself in these areas, but rather conduct itself cautiously. Balliet (1913:686) recommended a modest approach to introducing aspects of sex education:

> In connection with lessons on morals, such as ought to be given in elementary schools, topics related to sex morality,

> like purity of speech, respect for women, avoidance of bad companions, etc., can be effectively discussed in class.

Struthers (1914:73) discussed the moral elevation that could be accomplished through forest schools, offering outdoor nature experience:

> ...the child has learned something in deportment, to lift his hat to a lady, to smile back 'thank you' for a service rendered, to eat and drink discretely at the table, to appreciate the beauty of a few wild flowers, the lure of the open woods, the majesty of the rolling sea, to recognize his Creator in the things of nature.

This education in morals, discipline and rectitude was considered to be practical education. It went together with training in specific skills and physical education to shape the rising generation into effective workers and home-makers. It was fundamentally sexist; different standards applied to boys and girls. In these areas, public health officials were firm advocates of a sexual division of education.

The main contours of health education through the schools in Canada and Britain were the same. The attempt was to teach the practical skills for healthy living which included a heavy dose of disciplined morality. There were differences in the character and history of specific programmes, but the basic goals were more or less the same. The differences between Canadian and British public health in the schools were located mainly in the area of direct provision rather than health education.

C. Practical Ameliorative Work

In Britain, this period saw the establishment of nationally coordinated programmes of school meals and medical treatment which increasingly provided goods and services directly to the children of the state through the schools. In Canada, such direct provision was not much in evidence. L. Struthers (1917:11) accurately described the state of the art in Canada when she wrote: "At the present time, therefore, health education is the fundamental basis of all school health work."

Health education, in the sense used by Struthers, did not only refer to the kinds of instruction discussed in the previous section. It also referred to programmes such as medical inspection, which were used to provide health and hygiene education to children and their parents. Medical inspection was the most important area of 'practical ameliorative work' directed at children in Canadian public health.

The medical inspection of school children developed rapidly in Canadian municipalities in the period covered here. The first systematic programmes of medical inspection in schools was introduced in Montreal in 1906. This was followed within four years by programmes in Vancouver, Hamilton, Sydney, Halifax, Lachine, Toronto, Brantford, Winnipeg and Edmonton among others (Sutherland 1981:346-7).

In Britain, the development of school medical inspection bridged over fairly quickly into a nationally-coordinated programme which provided treatment of the health problems

detected. This did not happen in Canada. Higher levels of government (particularly the provinces) were generally involved only in the role of passing permissive legislation. More importantly, the systematic development of medical treatment did not occur.

In Canada, the emphasis instead was on using the school nurse as the agent to promote changes in home feeding and parental responsibility for treatment. As the official in charge of medical inspection in Toronto wrote, "...experience has proved that medical inspection fails to produce results without the trained nurse." The instructional and supervisory responsibilities of the school nurse extended far beyond an immediate medical condition. L.Struthers (1917:11) wrote, "To cure disease or remove physical defect is but an incidental part of the work." Lewis (1982:140), for example, described the agenda for home visits in Vancouver medical inspection:

> Home visits constituted a routine part of school nurses' duties. At that time, nurses encouraged parents to have their children's defects corrected, instructed parents on home ventilation, selection of proper clothing, infant care, children's sleeping habits, nutrition and hygiene.

This emphasis on hygiene education and nursing visits did not mean that treatment was totally excluded in Canada. School nurses in Toronto sometimes provided treatment in cases where parents could no afford to pay (ibid:9). A school clinic to provide treatment for the children of parents who could not pay was established in Vancouver in 1914 (Andrews 1979:184).

Treatment, however, remained secondary in Canadian public health activity in the schools in this period.

> The great aim of medical inspection of schools should be preventive medicine, not curative. Treatment or procuring treatment must necessarily be a part, but education constantly teaching the laws of health should be our greatest work (W.Struthers 1913:68).

Similarly, the approach to malnutrition concentrated on dietary education rather than school feeding in Canada. The contrast between British and Canadian public health was particularly sharp in this area of practical work in the schools. Here, the arching of British policy towards medical and economic forms of regulation can be detected in a period where the focus in Canada was primarily moral and educational.

4.3.3 Comparison: The Hygienic Family in Canada and Britain

It should be clear from the preceding two sections that the public health programmes directed towards the formation of the scientific family in Britain and Canada resembled each other in broad strokes. In both countries, the emphasis was on inculcating standards of discipline, authority and order and then enforcing these standards through periodic supervision legitimised on the basis of specific calling cards.

These general similarities derived from the position of public health in the forefront of social policy in this period, defining new problems according to an environmentalist sociology which leaned heavily towards idealism. The development of practical skills and moral standards were together seen as the

basis on which the working class could regenerate itself. To go beyond such educational objectives in the direction of state provision risked breeding dependency and destroying the autonomy of the family which was at the same time the dependence on the wage form.

In Britain, however, the beginnings of a shift way from this approach were clearly present. This was apparent in the areas of school meals and medical treatment. Here, direct benefits and services were being provided to children in need. By the end of this period, public health was coming increasingly to mean the provision of medical treatment. Newman wrote in the first Annual Report of Britain's new Department of Health:

> ...the progress of this form of sanitation and the advance of the science and art of medicine have moved the centre of gravity from external matters to personal matters, and from sanitation to preventive medicine, a preventive medicine which is positive rather than negative and which includes curative treatment (UK.Health 1920:9).

In Canada, this did not happen to the same extent. Certainly, there were local initiatives which ventured into areas of direct provision. But in general, the focus of public health was educational and the problem of provision was left to the family. There was no equivalent to such national programmes as school meals, medical treatment in schools, or national insurance.

It was argued in Chapter Two above that this change towards direct provision and curative treatment in British public health was an important part of the broad shift in social policy towards economic (e.g. welfare benefits) and medical (e.g. state funded

health care) regulation. This shift was underway in Britain earlier than in Canada as a result of the higher level of working class organisation and activity and of the legacy of previous social policy developments such as the Poor Law which profoundly affected the way new policy issues were defined and acted upon.

In Canada, this shift in social policy was not yet underway in this period. Public health retained its broad environmentalist theories and its instructional or supervisory practice. At the end of this period, glimpses can be viewed of the reorientation which would eventually take place. The development of clinics to treat people with sexually transmitted diseases and local initiatives to introduce school clinics were programmes which marked the beginnings of a change.

Public health was on the leading edge of the state regulation of the family in the early twentieth century in both Canada and Britain. The problem of the working class family was seen as one of poor hygiene linked to ignorance and demoralisation. By 1920, this conception of the family problem was changing dramatically in Britain. The definition of curative treatment as a significant public health approach in the first annual report of the British Ministry of Health could be taken as the mark of this important turn. In Canada, there were early indications of this turn at the end of this period, but the transition was not yet underway.

CHAPTER FIVE
Public Health as State Regulation

5.1 The New Hygiene as a Moment in Social Policy

This thesis has situated early twentieth century public health as a moment in the development of social policy, understood as the state regulation of working class social reproduction. In the first two decades of this century, public health played a leading role in defining new social problems and attempting to solve them by means of the state. This was an important period of transition in the development of prescriptive social policy in Britain and Canada, what has been called here the nationalisation of the working class. Public health provided the theoretical tools and practical direction for new programmes which aimed to delimit the national working class and to establish standards for its reproduction through the family system.

The general orientation of British and Canadian public health in these new areas of policy was substantially similar. The primary focus in both countries was on a project of standardisation, the establishment and enforcement of standards of competence and moral conduct governing the reproduction of the working class. This was to be accomplished through the use of methods of improvement and exclusion. Improvement centred on the use of education and supervision along social work lines in order to regulate women's domestic labour and the formation of the next generation. Exclusion centred on the use of immigration controls

and institutional segregation to eliminate or prevent the entry of those deemed in capable of meeting standards.

The specific programmes developed in Britain and Canada in this period to promote improvement included various forms of home visiting, clinics and exhibitions, and activities in the schools ranging from health education to medical inspection. Exclusion was to be accomplished through such programmes as the medical inspection of immigrants and the identification (through testing) and segregation of the mentally handicapped.

British and Canadian public health, then, cultivated new areas of social policy in very similar ways. These similarities derived from a shared conception of the nature of the problems to be solved in working class reproduction. In this period, the major problem in working class reproduction was seen as the environmentally-induced moral decline which undermined the working class family. This moral decline sapped the will and diminished the skill required to produce healthy families through the domestic labour process.

This sociology of moral decline was articulated with germ theories of disease transmission in the theory and practice of public health. The spread of germs could be halted through the development of scientific standards of order and cleanliness in the home. The primary impediment to the development of these standards was the ignorance and demoralisation of the home-maker. Thus bacteriology supported sociology in identifying illness with moral decline.

This moral and environmental conception of problems in working class reproduction was expressed through theories of race degeneration. This conception fit the particular requirements of social policy in this transitional period. In contrast with earlier views of poverty as individual moral failing, it defined the need for systematic state activity. Yet it did not threaten the wage form. The self-reliance of working class families, which is to say their absolute dependence on wage-labour to secure the necessities of life, could in no way be impaired by moral elevation.

This moral approach to social policy would soon be replaced by an economic and medical one. Unemployment would come to be seen as an economic problem facing all workers rather than a moral failing of the pauperized strata. New welfare benefits would supplement the wage in specific ways, addressing particular shortcomings of the wage form as the basis for family reproduction. New specialized services (such as medical treatment), simply unaffordable on the basis of the wage, would be provided on an accessible basis.

This change was completed with the development of the welfare state after World War 2. Movement in that direction was already evident in Britain during the period under examination here. This new direction in social policy was being developed in Britain but not in Canada as the result of two primary factors.

First, the further development of British social policy was impelled by the greater degree of activity and self-organization

and militancy among workers in this period, posing the working class question in new and sharper ways. Secondly, the British state operated within constraints deriving from previous social policy initiatives, earlier responses to developments in the class struggle such as the Poor Law. "The tradition of all the dead generations weigh like a nightmare on the brain of the living" (Marx 1959:398). The Poor Law acted consistently as a mechanism which translated general problems in working class reproduction into specific problems for the state.

These differences in the broad social policy context between Britain and Canada were reflected in specific differences at the level of public health. The further movement towards medical and economic regulation in Britain manifested itself in public health in the greater development of direct provision, the tendency to define medical treatment as preventive medicine, and the decreasing use of broad typologies concentrating on character. These changes were uneven, as this was a transition in progress. Nonetheless, they marked important steps in the process which would see public health relegated from the front ranks of social policy to the tail end of medical care.

During their moment in the front ranks, public health officials developed a very broad theoretical analysis of the process of working class reproduction. This was a necessary guide to their activity in as yet uncharted areas of social policy. Of particular interest here has been the way that family

and nation were used as orienting principles shaping this analysis of working class reproduction.

Public health in this period aimed to serve the interests of the nation by developing a healthy working class capable of industrial production or military activity. This was to be achieved largely through the regulation of women's domestic labour and the restriction of immigration. National well-being in the interest of all was to be achieved through the reproduction of the working class as wage-labour, the control of the private domestic labour performed primarily by women, and the fragmentation of the working class into national sections. This is a useful example, then, of the way apparently neutral social policy can identify the specific conditions for the reproduction of the capitalist mode of production as the general requirements for the perpetuation of human social life.

The retrospective analysis of this body of theory not only reveals the basic premises underlying its apparent neutrality, but also the basic contradictions which determined its shape. Public health in this period aimed at once to nationalise the working class and to reinforce the private nature of its reproduction through the family system. The contradiction between state regulation to establish national standards and the autonomous realm of the family emerged in many forms in the theory and practice of public health.

The need to provide minimal necessities of life in order to ensure certain levels of working class health conflicted with the

perpetuation of absolute dependence on the wage. The need to place domestic labour under supervision conflicted with the private character of that labour motivated by (socially structured) conviction. The need to standardise morality as part of the project of regeneration conflicted with the realm of autonomy of the person which is one of the aspects of 'free' labour under capitalism. The need to regulate sexuality necessarily risked tearing through the blanket of silence, fear and suppression which served as another form of control. Finally, the need to 'free up' women for private domestic labour conflicted with the demand for women in the labour market and women' own needs for subsistence.

The circuitous routes followed by officials to navigate around these contradictions have been traced in detail through this thesis. These contradictions persist in various forms to the present day, deriving as they do from the fundamental character of the capitalist reproduction process, combining wage and domestic labour under the regulation of the state. Ultimately, only the socialisation of production and reproduction under workers control can overcome the contradictions between social production and private reproduction under capitalism.

5.2 Public Health and the Limits of the State

This thesis has constituted an argument that the dynamics of public health can be understood in terms of a Marxist analysis of the state regulation of working class reproduction. This

analysis explains the non-neutrality and the limits of public health. Public health officials attempted to use state power to improve the national health within the limits of capitalism. The limits of the capitalist state not only defined the bounds of practicable reforms, but also infused the very conception of the health of nations.

Public health has often been used as an alternative model by critics of contemporary health and social services. It seeks to prevent disease by rooting out the environmental and social conditions which caused ill health. It links physical, mental and moral well-being, avoiding the fragmentation of the patient into ailing parts so common in contemporary medicine. It has a collective orientation, aiming to improve the health of the community as a whole, rather than concentrating on the treatment of individuals.

The first two decades of the twentieth century saw the high point of public health in Canada and Britain. It was at the heart of the theory and practice of state medicine and on the leading edge of social policy. It was expanding rapidly, particularly in the areas of home visiting programmes, services to infants and schoolchildren, the medical inspection of immigrants and the prevention and treatment of certain key diseases (particularly tuberculosis and venereal diseases). In this period, the horizons of public health seemed boundless, as officials envisioned the cradle to grave supervision of the

everyday life of the population combined with the strict medical selection of immigrants.

Public health was soon after reduced to a relatively minor field within modern medicine. This study has explained the rise and fall of public health in the fields of medicine and social policy. It has examined the constraints of public health at its pinnacle, relating these to the limits of the capitalist state.

Public health at its pinnacle did aim to prevent rather than treat disease, and yet was highly constricted in the identification and elimination of causes of ill health. Commonly, the conditions seen as causing diseases were those which could be changed within the limits of existing social relations. Sheer poverty thus tended to be played down as a cause of illness, while bad habits and attitudes or poor planning were emphasised. Even where poverty was explicitly identified as a cause of ill health, public health officials could do little but decry it.

Public health did take a more holistic approach to the human being than is often the case in contemporary medicine. Yet this approach was still linked to a functional orientation in which health was measured by ability to fulfill specific socially-determined tasks, particularly paid employment for men and domestic labour for women.

It did emphasise the health of the community rather than that of the individual. This community was, however, divided along lines of class, gender, race and nationality. Rather than

undercutting these divisions, public health reproduced them as absolutely essential conditions of natural and social order.

In short, public health in the early twentieth century came close to being a rounded and comprehensive approach to the regulation of social reproduction, the process through which the existing generation of producers is maintained, supplemented and replaced. As such, it had certain strengths and achievements. Yet this process could only mean the reproduction of existing social relations. The systematic roots of poverty, inequality and alienation lay beyond the realm of public health, indeed beyond the reach of the capitalist state.

1. Newsholme was a prominent British public health official, whose biography can be found below in Appendix 1.

2. For a brief biography of Bryce see below Appendix 1. Nor was this quote from Bryce exceptional. See below, section 3.2.1 for similar quotes.

3. The term and concept come from Harris (1980). The nationalisation of the working class is discussed below, section 2.2.1.

4. The method of Marx's 'science by criticism' is examined thoroughly in Sayer (1983:105-141).

5. Examples are given below, Chapter 2, n.5.

6. Thus, the limits of capital become the bounds of state activity. See (Clarke 1983:123-4).

7. It is this process of taking the historical and transitory characteristics of capitalism as eternal that is the defining feature of bourgeois ideology.Clarke (1980:16). It is a defining feature of the ideology of the capitalist state (Corrigan, Ramsey and Sayer (1980:10) and Corrigan and Sayer (1985:4-5).

8. Bevan (1952:73), the Labour Party cabinet minister who presided over the introduction of the National Health Service in Britain, was very much impressed with public health. He called preventive medicine "much the most important for mankind", admiring in particular its collectivist orientation. See citation of Bevan below, p. 21). Bevan's admiration for public health was not reflected in the final form of the NHS. Rather, the final form of the NHS was, in the words of Doyal (1981:182), " ...a clear illustration of the declining prestige of public health in the twentieth century..."

Tesh (1982:321) discusses the contemporary "new environmentalists" and their call for "a new public health revolution". Certainly concerns ranging from pollution and environmentalism to industrial health and safety, from lifestyle health fads to AIDS, have restored a bit of the "declining prestige" of public health since the 1960's.

9. Johnson (1982:156) described Marx's method as a circuit moving from the concrete to the abstract to the concrete. This circuit has two moments: concrete-abstract, generalisation to construct theory; and abstract-concrete, engagement with actual events. As is obvious from the circuit analogy, the process does not have a discrete beginning or end.

10. See Chapter 2, note 20.

11. Let alone the comparison with the United States and other countries, developed or colonial in the period, that would vastly enrich this thesis.

12. The thesis argues that the public health policy structured supervision of women's domestic labour and immigration controls around the question of the healthy working class. It suggests, in other words, that these are not separate questions related through some articulation but aspects of the same question, the social reproduction of the working class as the crucial condition for the perpetuation of capitalism. Unfortunately, it lies beyond the parameters of this piece of work to fully locate this account within the vast literature in this area.

1. Gough (1979:44-5) characterised the welfare state as: "...the use of state power to modify the reproduction of labour-power and to maintain the non-working population in capitalist societies." Public health was one of the earliest examples of such a use of state power. I use the term 'social policy' rather than 'welfare state' as the period I cover predated most of the benefits commonly associated with the welfare state after World War 2.

The definition of public health as a form of social policy raises the problem of accounting for those activities which lay outside the purview of the state as such. Public health was supported by influential pressure groups extending from the Health of Towns Associations in the mid-nineteenth century to a range of social, moral and health reform groups in the early twentieth. Some philanthropic groups offered public health services independent of state funding, including the health visitors of the Manchester and Salford Ladies Sanitary Association in Britain and the visiting nurses of the Victorian Order of Nurses in Canada.

I would argue that the presence of voluntary public health activity does not exclude the definition of public health as state social policy. Public health, whether in its official or philanthropic forms, was consistently oriented around the use of state power. The state was seen as the only body with the power and resources to develop and enforce public health services and regulations. Thus, philanthropic services tended to be incorporated into the state once they had proved themselves as 'test cases'.

More importantly, the position of the state was seen as privileged in public health as it was the embodiment of the interests of all, the general against the specific, the nation (or city or province) as opposed to its parts. This privileging of the state lay at the heart of public health theory and practice. This meant the perspective and limits of the state tended to be reproduced throughout the field of public health, whether in its official or voluntary forms.

2. Bates (1918a:56) identified the major public health methods as "education, inspection, quarantine, compulsory treatment". Provided that immunization is included under compulsory treatment, this sums up the basic preventive methods.

3. See Clarke 1983:124-25

4. The particular interest that Chadwick encountered most directly was that of local authorities, largely representing small property. He saw these as narrow-minded obstacles to be surmounted by professional staffing under central authority, "lifting these important branches of administration out of the influence of petty and sinister interests (Chadwick 1965:380)."

He referred to the obstacles posed by narrow-minded proprietors as well as the dangers of working class organisation (e.g.ibid 266-67,344, 357). Providing these could be overcome, public health was one of the mechanisms which could contribute to the good of all by enhancing the lives of workers while improving productivity and decreasing rates for the propertied (e.g. ibid 293,298).

5. John Simon argued, for example, that in the area of industrial health and safety workers could do nothing and employers would do nothing (Lambert 1963:333). P.H. Bryce (1915:51) stated, "Too often has capital been proved to be a veritable Gargantua of insatiable appetite slowly immolating his victims." See also Barr (1907:517).

6. Chadwick's report and the link between public health and pauperism is discussed below, section 2.1.2.

7. Within this set of diseases there was a specific focus on contagious diseases linked particularly to the fear of epidemics (Flinn 1965:8-12, Teah 1982:322-3).

8. This emphasis on enhancing the ability to labour is illustrated by a quote from Bryce (above p.4) and discussed below section 3.2.1.

9. For example, see above p.2.

10.Berliner (1977:117) wrote that the definition of health was established through class struggle.

> The struggle over the control of the definition is an aspect of the class struggle in which capital tries to define health in terms of production (functional health), while the working class tries to define health in terms of control of its own destiny (experiential health).

This is true, providing that we understand that this is generally played out indirectly rather than directly. Implicit in the struggle over wages, the length of the working day, health and safety and ultimately control over the workplace and society is the question of the health of the working class as linked to the individual and collective realisation of human potential.

11. The reproduction of the working class as wage labourers included the reproduction of a section of the class as (full or part time) domestic labourers, as discussed below pp.105-08.

12. See Eyler (1979:103-7) for a discussion of Farr's 'zymotic theory' in which the zymotic disease agent was dependent on atmospheric conditions. See also Rosen (1958:268-9) and Frazer 1950:68) for discussions of the development of nineteenth century

disease theory to account for spread between people or people and animals.

13. This was a favourite term in early twentieth century public health, seen for example in UK.LGB (1913b:89).

14. Chadwick was concerned about the link between overcrowding and demoralisation (1965:193), intemperance (ibid:199,308), household management and skills of women in the home (ibid:195, 217-18), the moral impact of personal cleanliness (ibid 300) and social peace and stability (ibid:266-67).

15. Simon studied infant mortality, nutrition, housing and other areas of concern to the new hygienists (see Lambert 1963:336-8, 340-1, 346-50, Frazer 1950:85-110). He was concerned about the material and moral impact of wages below the subsistence level (Newsholme 1925:13, Ont.PBH 1899:24). However, he had no method of intervention for dealing with these concerns (see below section 2.3.2).

16. Farr argued for limited forms of social insurance as an antidote to social unrest:

> Anarchy, riot, insecurity of life, communism, are common and ever recurring symptoms of this constitutional evil in countries where the owners of property have not yet discovered that the appropriation of a small part of the profits, as a premium for the insurance of the life of the population, is at the same time a cheap insurance of their titles and possessions - that the insurance of the life of all, is the insurance of the property of all (cited Eyler 1979:86).

17. This argument can also be found in Lauder (1908:91) and B.Webb (1909:153).

18. The open air life is discussed in various degrees in Gardiner (1904:887, Myers (1908:43-44), Newsholme (1903:257), W.Struthers (1914:72-3) and L.Struthers (1917:132-43). It was not based on germ theory, but (at least in Struthers' version) on the theory of the aerial envelope:

> The condition of the aerial envelope, or body air, depends on temperature, humidity, the tonicity, and movement of air. Heated air loses its vitality or tonicity. Elaborate experiments have shown that the condition of this aerial envelope is a very important part of the hygiene of the body, and had a very marked effect on the health (L.Struthers 1917:135).

19. See Thane (1982:14). This distinction had a long tradition, but was subject to reinterpretation as the framing of the poverty

question changed (see Stedman Jones 1971:285). It was present, for example, in Chadwick's (1965:198) report, expressed as a concern about the mixing of respectable workers and people from the degraded strata:

> The indiscriminate mixture of workpeople and their children in the same immediate vicinity, and often in the same rooms with persons whose character was denoted by the question and answer more than once exchanged, 'When were you last washed?' 'When I was last in prison', was only one mark of the entire degradation to which they had been brought.

20. Stedman Jones (1971:245-55) stressed that the latter, the damage of indiscriminate charity, was seen as the primary problem to be answered through case work and charity rationalisation.

21. See Stedman Jones (1971:255,297) and Thane (1982:14,22-4) for a discussions of casework, the poor law and the streaming of the impoverished.

22. Discussed in Stedman Jones (1971:285).

23. This elements in this crisis included economic depression and increasing resistance, culminating in the such events as Trafalgar Square riot of February 8, 1886 and similar street clashes in 1887. Of particular concern to the ruling class at the time was the possibility that unemployed agitation might link up with the working class. The immediate impact of the Trafalgar Square riot on the consciousness of the bourgeois classes was demonstrated by the sharp leap in contributions to the Mayor's relief fund afterwards (see Gilbert 1966:33-6, Stedman Jones 1971:290-97, Thane 1982:15).

24. The intensification of labour in the process of social production was achieved through mechanisation and scientific management (Taylorism). This intensification not only increased productivity but also strengthened employers' control over the labour process. It represented at once a new strategy in the class struggle (intensifying labour vs. lengthening the working day) and a new mode of accumulation, the dominance of relative (increasing the productivity of labour) over absolute (extending the working day) surplus value. See Aglietta (1979:113-130) and Braverman (1974:85-121).

25. Kay and Mott (1982:139-41) describe this as the incorporation of the working class into the state and the formalisation of class struggle. See also DeVroey (1984:48), linking collective bargaining to the transition from extensive to intensive accumulation.

26. The earlier proscriptive period is described in Finer (1952:178-80) Corrigan and Sayer (1985:114-16) and Ginsburg (1979:29-31). The characterisation of social policy in this period as primarily proscriptive does not imply that it had no prescriptive content. As Corrigan and Sayer (1985:115) wrote:

> The story we wish to trace, then, is not only one of violent repression, there is more 'subtlety' than that. Equally to be witnessed is a concerted moral revolution, an attempted organization of consent and incorporation...

In the earlier period of social policy, this moral revolution largely took the from of suppressing alternatives. Violence, social and moral classification campaigned with explicit efforts at education in this early period of social policy (ibid.:136-140)

27. This schematic sketch of the path of development of social policy combines a number of sources, perhaps committing an injustice to the subtleties of all of them. These were: Tomlinson (1981: 14-15,62-72), Corrigan and Sayer (1985:171) Kay and Mott (1982:107-110) Topalov (1985:258-61) Stedman Jones (1971:127-9,254-5,276-7,281-314), DeVroey (1984:48-53), Aglietta (1979:180) and Clarke (1988).

28. The actual dating of this process is rather difficult. Corrigan and Sayer (1985:171) stress the continuity of the post-1880 reforms in Britain with those of the earlier (e.g Chadwick) era. It could be argued that in some ways this first period stretched from the 1840's-1920's in Britain, and from the 1880's-World War 2 in Canada. The important thing is not the dates, but rather the boundaries of the period beginning (at the level of theory) with the 'discovery' that poverty was not simply the fault of the poor and ending with the recasting of poverty as the economic problem of unemployment (handled through benefits) and the medical problem of illness (handled through state-funded health care). In terms of policies, the period dates from the philanthropic and local experiments in social work methods to the introduction of modern social insurance.

29. In Canada, the most important jurisdiction for health was not the federal government (which created a Ministry-level Department of Health in 1919) but the provincial governments. Many provinces created Ministry-level health departments around this period including: New Brunswick (1917), Alberta (1919) and Ontario (1923) (Defries 1940:73,143) (LeRiche 1979:156,158)

30. Frazer (1950:1-2) connected the origins of British public health to the development of dense urban centres. Previously, concerted state action in this direction had been unnecessary:

> Action by the state to influence in a favourable sense the health of the community was largely unnecessary during the centuries when England possessed a small population living almost entirely in rural surroundings and spread thinly over the surface of the countryside.

Of course, the health problems of sparser rural populations must not be denied. But Frazer was right in connecting state public health to "the packing of large populations on limited areas of land without providing for sanitation or for cleansing."

31. The link between Chadwick's reforms of the 1830's and 1840's and the social upheaval of the period is discussed in Finer (1952:142,169,178-80,182), Checkland (1974:24-6) and Richards (1960:67,72-6). This was not a one-way relationship in which working class activity necessarily triggered a state response. State programmes could also trigger working class resistance (as Thompson (1984:29-30) argued the New Poor Law did the Chartist movement). This generated new problems for the state, potentially solved by repressing the resistance, altering the contented programme or introducing innovations in other areas (further displacing the issue).

32. The relationship between the disturbances of the 1880's and the re-conception of social reform is discussed in Stedman Jones (1971:261-99) and Thane (1982:15).

33. The pre-World War 1 upturn in British working class struggle is discussed in Haynes (1985:99-100) and Benson (1985:66). The impact of this upturn as a stimulus on state policy is discussed in Thane (1982:61).

34. See Palmer (1983:98-130) and Lipton (1968:58-78) for assessments of the Knights of Labour in this period. These sources as well as Guest (1980:19-24) also report on the 1887 Royal Commission.

35. Palmer (1983:147-9) described a boom in working class organisation from 1897-1904, a holding pattern until 1915, and then an explosion peaking in 1919.

36. Examples of specific connections between working class unrest and public health programmes include Chadwick (1965:266-68), Conservation of Life (1919b:31), Industrial Canada (1912:1049) and Clarke (1919:443-4).

37. The link between imperialism and social policy breakthroughs is the specific subject of works by Semmel (1960) and Davin (1978). The impact of imperialism on British public health and social policy is also discussed in Thane (1982:58-9) and Gilbert (1966:72-91).

38. These influential remarks were cited, for example, in a Presidential Address to the Canadian Public Health Association (Hodgetts 1912a:544-6).

39. Hyam (1976:74-83) traced the hardening of racial attitudes back to the 1860's, linking new pseudo-scientific theories of racial difference to the experience of Empire, and particular the resistance of the ruled. This resistance (for example in the Jamaica crisis of 1865) was taken as a sign that blacks could not rule themselves in the proper British manner.

40. See Eyler (1979:156) re:Farr and Nightingale. Bryce (Ont.PBH 1899:25-6) cited a long statement of Simon's regarding the 'deterioration of the race.'

41. Examples of this range of views on urban life include, Legge 1904:947, Carter 1906:45, Bryce 1912:667-9 & 1915:49-55, Hodgetts 1912a:543.

42. Some Canadian officials came very close to arguing that cities grew through irrational processes and were economically regressive. Bryce (1912:667-8) argued that with the exception of England, "...there must be a good majority of prosperous agriculturalists in any population, as in Denmark, if a country is to be contented and really prosperous." Similarly, Clarke (1919:443) argued that it was economically irrational that immigrants to Canada settled in cities: "...immigration went, not to the land where it was required, but to the urban centres where it was not either desirable or particularly beneficial..."

These views were strongly challenged in the journal Conservation of life (1914:30-1), which argued that the regulation rather than restriction of urbanisation was required.

43. See Stedman Jones (1971:127-131). Gilman (1983:35) defined degeneracy as used in this context:

> It describes the propensity of people to contract diseases, both physical and moral, and to pass them on to other generations.

44. See also Newsholme (1905:67).

45. The immediate context for the move of race degeneration theories to the heart of public health was the debate over the poor quality of recruits available to fight the Boer war (see Frazer 1950:242, MacKintosh 1953:8-9, Davin 1978:11, Gilbert 1966:61). This debate served as a catalyst, adding a new initiative to developing concerns, programmes and perspectives.

46. Before the Darwinian paradigm rose to dominate theories of evolution, the Lamarckian model which stressed the hereditary transmission of acquired characteristics was dominant.

47. Nordau (1968:6-7) wrote, "Here is the place to forestall a possible misunderstanding. The great majority of the middle and lower classes is naturally not fin-de-siecle." 'Fin de siecle' was Nordau's term for the degenerate mentality.

48. Committed eugenist articles in public health journals at the time included those by Barr (1907 & 1911), Reid (1913a&b), Shortt (1912) and Clarke (1916 & 1919). Not surprisingly, Barr's articles also contain the most overt racism I found in British or Canadian public health journals, as for example in the statements: "It is this acquisitive ingrained habit which prevents the Jew from ever taking a leading position in the world...the same evil habit crops up wherever they are (1907:517); or describing a cabinet minister, "...whose imitative faculty is so strongly developed that he might be readily mistaken for a Jap in place of a Welshmen (1911:715)."

49. See Barr (1907:515) for a similar statement of the desirability of artificial selection.

50. Searle (1981:223-6) counted MOHs among the professional groups critical of eugenics on this basis. He wrote, "...[MOHs] saw the eugenists' preoccupation with heredity as a threat both to their raison d'etre and to their career prospects (ibid:224)."

51. Similar arguments are found in MacMurchy's reports on infant mortality in Ontario (see Ont.Reg-Gen 1910:4,1911:19).

52. This argument can be found in the British Royal Commission on the 'feeble-minded' (UK.RCCF-M 1908:180-85), MacMurchy's reports on the 'feeble-minded' for the Ontario government (see 1907:29, 1909:15, 1910:8, 1912:5-6, 1914:13) and a number of journal articles (e.g. Downey 1913:124, Pattin 1909:41).

53. This is one of the bases on which public health became involved in questions of birth control, purity and sexuality. See below, section 4.1.C.

54. Morgan (1906:336) distinguished between degeneration, "a lowering of the hereditary possibilities" and deterioration, "failure in the due development of hereditary potential." This technical distinction was not widely followed in public health journals, where degeneration was used broadly in both senses.

55. A similar view of the priority of moral formation is found in the statement:

Unless we educate the slum dweller to the dangers of unsanitary methods of living, the placing of them in proper homes will not materially decrease our mortality (Hastings 1917:88)

56. See below, section 4.2.2.C. for a discussion of school meals and medical treatment. In those areas where public health officials were involved in direct material provision, they tended to proceed through cautious local initiatives to test the method before gradually generalising. In short, they resisted institutionalising direct provision as a principle until it was proven in practice to be compatible with family self-reproduction.

57. Bliss (1970:101,104) discussed this idealistic orientation of the social reform movement in an article on the sexual purity movement.

58. Grandmother-bashing was a favourite of public health officials. Examples include: Kerr (1910:129) and Moore (1906:22)cited below p. 266, as well as L.Struthers (1917:129) and W.Struthers (1914:68). MacMurchy cast her net a bit wider, blaming bad advice on "the mother-in-law, or the sister-in-law, or the nurse, or the neighbour, or some other meddling busybody" (Ont.Reg-Gen 1910:2). Clearly there was only one type of meddling to be tolerated, and that was the intervention of the home visitor, backed by science and sanctioned by the state.

59. Hill (1920:19) discussed the pragmatic basis of the new hygiene in opposition to broader social and material reform "Consider the utterly impracticable expense and difficulty of the attempt to insure only the four quoted factors - good food, proper temperatures, temperance and repose..."

60. I agree with Hall and Schwartz (1985:8) in their rejection of "the idea of any adequate general theory of the state from which British particulars can be deduced." The explanation of specific historical developments cannot simply be deduced from general theoretical premises. Yet the answer to this problem is not necessarily to be found in "emphasizing the peculiarities of the British route". It is of course essential to do detailed concrete analysis of specific cases, whether at the local, provincial, national or international level. Whatever the level of analysis, though, it is essential to understand that each capitalist state exists only as part of a world system of states, and the contingent factors of national (or local) development must also be connected to international conditions (see Barker (1978).

61. The first major piece of comprehensive public health legislation in Canada was passed in Ontario in 1884 (preceded by preliminary legislation in 1882). This legislation was specifically modelled on the British legislation of 1875 (LeRiche 1979:158).

62. The comparison of Canadian and British public health in this period to developments in the United States would be an interesting study. There were substantial similarities between conditions in Canada and the United States in this period, particularly regarding the importance of immigration. The American influence on the new hygiene as developed in Canada was quite marked.

Unfortunately, the comparative study of the United States lies beyond the parameters of this thesis. Here, the comparison is between two countries at different places within the imperialist project, at somewhat different levels of industrial and urban development, with different histories of class struggle and organisation. This comparison is adequate to bring the thesis out of the limits of explaining public health in terms of internal developments in particular nations, showing the international dimensions of social policy without losing touch with specific national patterns.

Certainly, there are many other comparisons that would have added to the thesis: with a less developed colony, with the United States, with a non-anglophone country in Europe. Such comparisons were simply beyond the limits of this thesis, and must await future projects.

63. This characterisation of the period and the general sketch of British social policy in this period come from readings of Thane (1982:65-90), Doyal (1979:163-71), Davin (1979:9-57), Tomlinson (1981:67-72) and Gilbert (1976:136,314-15;449).

64. See Thane (1978:100-4) for a discussion of the development of the non-contributory Old Age Pensions scheme, the strict conditions limiting eligibility for benefits, and the lessons learned from the experience by policy-makers who then developed national insurance on a contributory basis.

65. Re: Canada see Palmer (1983:147-73), Lipton (1968:266-75) and re:Britain see Haynes (1985:99-100), Benson (1985:66), Thane (1982:81) and Hobsbawm (1969:165).

66. This topic deserves more attention than I can give it here. The sources which discussed the impact of frontierism on domestic policy in my research were: Hogan (1985:35-51), Aglietta (1979:75;130) and Wallace (1950:386-7).

67. See below section 2.3.2. for a more specific discussion of this.

68. This reform movement has received considerable attention in the past fifteen years. The sources that I have drawn on were: Sutherland (1976:18-27) and Lewis (1982:135-9) on reform and child welfare; Bacchi (1978:460-7) Roberts (1979:18-26) and Kealey (1979:2-7) on the women's movement and social reform; Rutherford (1974:ix-xxi) and Piva (1979:75-80,115-34) on urban reform and Bliss (1970:89-107) on the sexual purity movement. Bliss (1970:101-4) is also valuable for his discussion of the social theory of the broad reform movement, particularly its idealist orientation. Finally, Cook (1985:26-8,173-180) discussed the ideas to leading reformers within a framework emphasizing the secularisation of morality in the era of science. See pp. 106-08 below for a more specific discussion of this.

69. For discussion of labour, the reform movement and the rise of local Labour Parties see Palmer (1979:112,157-9) and Cook (1985:107,152-172,196).

70. Conservationism and public health are discussed in Smith and Witty (1970:59-70), Artibise and Stelter (1981:17-18,23-6), Armstrong (1968:21-32) and Hall (1985:254-57).

71. This way of understanding social policy comes from Corrigan (1977) and Abrams (1968). Corrigan (1977:viii-ix,115) wrote that these pioneering state policy-makers (whom he called state servants) operated with a coherent sociology, involving the use of particular methods and theoretical perspectives.

72. Thus, statistics are a historically specific product of the capitalist state.

> Population as a fully developed category not only presupposes a universe of equivalent individuals, but also a universal object to which they are related, namely the state (Kay and Mott 1982:91).

This apparently natural universe of equivalent individuals was the product of capitalist social relations. In contrast with previous modes of production, capitalist relations create individual equivalence at the level of the workplace (the contract between workers and capital) and the state (creating subjects/citizens). This equivalent individualisation, which obscures fundamental class relations, is the starting point for the statistical appropriation of social facts. (See Marx (1973:264-5), Kay and Mott (1982:62-6) and Corrigan and Sayer (1985:135)).

This statistical method at once breaks down particular experiences of class, race, gender, etc. into a single distributive universe; and at the same time individualizes the subjects within that universe. Corrigan and Sayer (1985:5) wrote:

> Centrally, state agencies attempt to give unitary and unifying expression to what are in reality multifaceted and differential historical experiences of groups within society, denying their particularity.

73. The flourish of investigation and policy initiative in the 1830's-40's is not surprising. It was a period in which the perpetuation of capitalist society was thrown into question by various forms of working class resistance, culminating in the Chartist movement. This resistance generated a range of problems for state policy. At a general level, state social policy can be understood as a response to the resistance of the working class.

> ...every innovation, new body tribunal or commission originates either directly or at one remove from working class resistance to the formal conditions of life (Kay and Mott 1982:96).

This resistance was acknowledged as a problem in contemporary reports.

> The Poor Law Report and its Appendices contain a good many references to the disturbances of 1830-31, the kind of action taken by the protesters, and the effect on the outlook of those who felt themselves vulnerable (Checkland 1974:25).

This resistance did not create a single policy question focussing on the whole of 'the condition of the working class'. Rather, solution-oriented inquiries were launched in a range of areas.

74. These early Commissions appear particularly impressionistic as statistical technique was not refined and the repository of accumulated facts was as yet quite small (see Abrams 1968:14-15,25-7; Eyler 1979:19; Flinn 1965:25-8). Of course, even the more solid technical basis of later reports, and the far greater weight of amassed data, did not alter the central importance of implicit theorizing and the emphasis on the 'informed' impressions of state officials or state-oriented thinkers.

75. Chadwick (1965:79) argued, for example, that the evidence submitted to him all pointed to one cause of diseases, 'atmospheric impurity'. He then cited an example of this evidence, the report of Mr. Gilbert, the Assistant Commissioner for Cornwall and Devon, on a walk through a particular district:

> Before reaching the district, I was assailed by a most disagreeable smell; and it was clear to the sense that the air was full of most injurious malaria.

This observation was then used by Chadwick as evidence that bad sanitation was a cause of disease, stating that Gilbert, "found the open drains and sewers the most prominent cause of malaria (ibid)." The 'finding' was based on the initial assertion that bad smells were a source of malaria.

Similarly, Chadwick's statement that "The occurrence of severe destitution is denied as a general cause of fever, not as a consequence" was not based on a thorough examination of systematically-organized evidence (see ibid 217, 98, 199 for discussions of miasma vs. destitution).

Chadwick was also quite willing to take theoretically-informed short cuts through his data. He wrote regarding a mass of data on mortality included in the report, "A complete analysis of the whole of the causes contributory to the premature mortality displayed in this group of cases would be a work of much labour, and would in nowise affect the soundness of the conclusions drawn from other sources, that a large amount, and probably the mass of it, is preventible (ibid:261, see also p.174).

76. Chadwick's politics were certainly there in his report, though they were not identified as the 'theory section'. His writings on the common interests of workers and capital, the labour theory of value, the road to social peace, etc permeate the report (e.g. 1965:167, 199, 251-3, 266-7, 298). Similar broad-ranging theoretical exploration can be found in later public health, for example in the work of Bryce (Ont.PBH 1899:21-24), Pattin (1909:40-1) and Smith (1902:525-31).

77. Similar emphasis on the persuasive power of facts and science can be found in Smythe (1918:68-72) with regard to venereal disease.

78. Areas of government specifically responsible for the accumulation of statistical information probably represent the major exception to this tendency.

79. See Bator (1979a:112-129) for an assessment of Hastings achievements, showing the broader social concerns (e.g. with housing) and the more specific achievements.

80. This point will be discussed in section 2.3.2 below.

81. The argument for state medicine was common in the public health literature of the time. In 1912, the Public Health Journal was subtitled 'State Medicine and Sanitary Review',

(though this was changed in 1913 to 'Organ of Official and Voluntary Health Administration' and then 'Official Organ of the C.P.H.A.'). Other examples of arguments for state control of medicine include Public Health Journal Editorial (1915:119) and Wesbrook (1912:493). The journal of the Royal Institute of Public Health in Britain was called the Journal of State Medicine for a time in this period.

82. This editorial was in a Canadian publication, the Public Health Journal. The British journal Public Health also published an editorial which generally supported National Insurance, through it did not discuss the issue of state medicine in the same way and raised specific questions regarding the place of public health in the new programme (Public Health Editors 1911:335).

83. The similarities between public health and Fabianism can be found in their respective views of eugenics, environmentalism, the importance of a sound working class, the extension of state regulation, the existence of an unchangeable residuum in the working class and the role of nation and empire. These similarities derive from a shared reform sociology based on the role of the capitalist state in the reproduction of the nation.

84. See, for example, LaBerge (1912:127), Wesbrook (1912:491), and Sutherland (1915:168). The convergence of public health with 'socialism' (i.e. Fabian social democracy) was perhaps best indicated by the (Canadian) Public Health Journal Editorial (1918:443) entitled 'The British Labour Party' which strongly endorsed Labour's platform for post-war reconstruction. In Britain, Sydney Webb (1909:66) addressed the Annual Dinner of the Society of Medical Officers of Health, speaking of their role as "the first missionaries" of the gospel of preventing destitution:

> It was because the Medical Officers of Health had been the first missionaries of this gospel, without quite claiming the full share of the credit they were entitled to, that he was glad to be present that night.

Public health played a pioneering role in developing programmes to improve the condition of the working class in the interest of the nation. This kind of programme was central to Fabian theory and practice.

85. This subordination of the individual to the state representing the national or community interest was a theme shared by public health and Fabianism. To be sure, this subordination had a radical element as it was clearly aimed at regulating the activity of capitalists as well as workers. For example, J.S. Woodsworth (1914:22), who was later to emerge as one of the founders of Canadian social democracy, wrote in Public Health Journal:

> And they [i.e. 'our human wastage'] can be saved only by a sane, intelligent well-regulated system by which private gain will be subordinated to community welfare (see also Bevan on public health, cited above p.21).

At the same time, this subordination clearly involved the development of what Stapleford (1918:289) labelled "this machinery of social control." In fact, this orientation to state social control went as far as Bryce (1915:210) expressing his admiration for the German (i.e. enemy) state during World War I:

> It breathes of the heroic, of consecration to duty, and of sensing the value of human energy in life. It would indeed be wholly admirable had the divine breathed into it a soul.

One of the crucial tasks of this machinery was "the establishment of a sound public opinion" (Adami 1912b:371; see also Stapleford 1918:288, Woodsworth 1914:21). The people who would administer this machinery were to be those experts who could scientifically and dispassionately act in the interests of the nation as a whole: experts (in the case of public health officials this quite specifically meant doctors).

> ...there are other elements in the body politic which have not the knowledge of or belief in the infallibility of our 'experimental method', our scientific procedure, to accept its propositions without question as being in the highest interest of the individual and the state (Public Health Journal Editorial 1912:199).

The assessment of this conception of infallible experts moulding public opinion and bending individuals (capitalists and workers alike) to the common good depends ultimately on the analysis of the capitalist state. Individual capitalists were to be compelled to subordinate themselves to the conditions required for the expanded reproduction of capital, or, in other words, to the conditions for the perpetuation of their own class rule; while for workers, this compulsion only reinforced the relations of subordination to capital.

86. This characterisation of the contrast between wage and domestic labour draws on Vogel (1983:151-5) and Lebowitz (1982:45-8).

87. The roots of this sexual division of labour are widely debated and cannot be properly explored here. This thesis makes some effort to explain the private character of domestic labour, but it cannot properly address the issue of "...why women do

domestic labour, how the work came to be both privatized and feminized" (Fox 1987:184).

In very general terms, I would follow Vogel (1983:153) in arguing that this sexual division of labour, "originates as a historical legacy from oppressive divisions of labor in earlier class societies." The sexual division of labour was the first form of division of labour in society. With the rise of class societies, sexual divisions of labour became the basis for women's oppression. Sexual divisions of labour, have been present through history, but they vary historically with the mode of production and with specific historical circumstances. Vogel (1983:149-50) wrote that sexual divisions of labour tended to be weakest in those moments in class society in which the importance of generational replacement is minimized (i.e. the labour force is replenished by other means such as migration).

88. There are notable exceptions, whether in the form of Cadbury's attempts to improve his workers through decent housing, education, etc. or the gyms and cultural activities centred around some Japanese plants; or the legacy of the company barrack (with curfews, drinking rules, etc.) or the company town (with the eviction of striking workers, etc.).

89. This response developed historically rather than through an abstract unfolding of the requirements of capital. Clarke's (1983:118) general analysis of the historical development of the state applies to the more specific realm of social policy.

> The necessity of the state is, therefore, not formal or abstract, it is the historical necessity, emerging from the development of the class struggle, for a collective instrument of class domination: the state has not developed logically out of the requirements of capital, it has developed historically out of the class struggle.

90. The contradictory trends of capitalism towards internationalisation and nationalisation are the subject of Bukharin's (1972) classical work. See also: Barker (1978) and Haynes (1985).

91. The identification and contradiction between capitalist and working class interests in the social reproduction of the working class is discussed in more detail in Lebowitz (1982:46-8) and Gough (1979:65-66).

92. This discussion of the relationship of the state and civil society draws on very interesting sections of Clarke (1988) and Sayer (1985).

93. The whole question of the relationship between state and philanthropic activity in this period is an interesting one which cannot be dealt with properly here. I would argue against drawing too sharp a line between state and philanthropic activity in this period. On the one hand, many voluntary organizations were oriented to advocacy of state reforms, seeing the state as the only incarnation of the general interest capable of protecting the health of the community. On the other hand, state officials were frequently active in voluntary organisations of various descriptions. I think that philanthropy in this period could be seen as a form of state activity, though I am not completely satisfied with the formulation, which requires further work and research.

1. It was not accidental that Chadwick's pioneering report was called Report on the Sanitary Condition of the Labouring Population of Great Britain.

2. Conservation of Life was the publication of The Commission of Conservation, an advisory body established by the federal government in Canada. The editors of the journal were not credited, though a note in Conservation of Life (1919:20) indicates that Charles Hodgetts, the medical advisor to the Commission of Conservation generally edited the journal and prepared the articles, rotating at times with Thomas Adams, the town planning advisor. The articles were frequently unsigned, and presumably the work of the anonymous editors.

3. This is a rather complete statement of the goals of public health at the time. This statement is just one of many outlining this basic sociology. Canadian public health officials were fond of citing British authorities such as Disraeli (cited at length, Adami 1912a:334; also cited Hodgetts 1912a:546), Lord Rosebery (Hodgetts 1912a:544), and Joseph Chamberlain (Hodgetts 1912a:544)
Statements about labour as the basis of prosperity can be found in Hodgetts (1912b:63), Conservation of Life (1919:25),Commission of Conservation (1910:12), Hastings (1917:51)& (1919:103-4), Bailey (1912:439), Molloy (1914:379)
Specific references to efficiency include: Woodbrook (1912:491), Struthers (1913:67), Molloy (1914:381).

4. See for example Frazer (1950:1-2).

5. The most important theoretical work on this contradiction is Bukharin (1972). This question is discussed in more detail in chapter 2. See also Harris (1980).

6. The imperialist dimension in the motivation of social policy reforms in this period is the central theme of Semmel (1960), who stressed the role of social reform in building a popular base for the imperialist project. The importance of imperialism in the transformation of British social policy in this period is also discussed centrally in Davin (1978).

7. This is an interesting area of public health which I will barely touch on. Public health was a necessary feature of imperialist conquest. Frazer (1950:267) described this in the following terms:

> Vast tracts of territory in Africa, India and other tropical parts of the globe can only be inhabited by the white man if he is protected from the parasitic diseases peculiar to hot and humid climates.

It follows then that such imperialist adventures as the opening of the Panama Canal should be described as "...a triumph to Colonel Gorgas and to scientific medicine" (ibid:268).

8. Glynn (1982:210-11, 217-18) wrote that over 80,000 British children were transported to Canada through assisted emigration in the period 1869-1924 along with 32,000 men and their families under the auspices of the Salvation Army from 1904-07.

9. See Glynn (1982:223) and Canada.Interior (1908:xxviii-xxix, 83, 116, 127-36).

10. See Chapter 2, note 48 for a discussion of Barr's views.

11. Avery (1975:25-8) gives examples of the preference for non-anglophone immigrant labour among certain employers because of their toleration for low wages and primitive working conditions, their vulnerability due to inability to speak English; i.e. as a source of cheap, malleable labour.

12. Both J.A. Smart and W.W. Cory, the successive Deputy Ministers during this period, were clearly on record as favouring British-origin immigration (Canada.Interior 1903:xxvii, 1905:xxvii, 1907:xxxvii, 1909:xxix, 1910:xxvii). Similarly, P.H. Bryce saw immigrants of British origin as culturally compatible and liable to integrate easily (ibid 1907:136). Examples of Anglo-Saxon chauvinism in the public health literature include: Bryce (1915:208), Page (1915:557), Laurie (1913:455).

13. Quarantine services continued after the development of medical inspection. Bryce described his services as "... the second line of medical inspection after the outer quarantine" (Canada.Interior 1910:11). Quarantine services aimed to detect and place in quarantine carriers of specific contagious diseases. Medical inspection selected suitable immigrants to Canada on health and other grounds.

14. Bryce's credentials are discussed in Appendix 1.

15. This is illustrated in the following table, showing the percentage of immigrants rejected or detained for eye disease:

Year	REJECTED	DETAINED
1904-5	80	9 0
1905-6	67	8 1
1906-7	45	7 9
1907-8	33	6 2
1908-9	23	2 6
1909-10*	78	7 9
1910-11	61	5 5
1911-12	43	4 1
1912-13	32	3 5
1913-14	38	3 6
1914-15	33	5 1

*N.B. Bryce described the increase in detentions and rejection for eye diseases in 1909-10 as an anomaly linked to the conditions on the ships of a new line carrying immigrants (Canada.Interior 1911:118). The magnitude of this increase is exaggerated in this table due to a change in reporting in 1909-10. In that year, detention or rejection for civil causes (lack of funds, criminality) was no longer counted in with medical causes. Thus, while eye diseases accounted for 23% of all rejections (medical and civil) in 1908-9, they accounted for 78% of purely medical rejections in 1909-10.

This table calculated from Annual Reports as follows: Canada.Interior (1905:125-6; 1906:121-2; 1907:127-8, 1908:121-22, 1909:106-7;1910:8-9; 1911:116-17; 1912:125-26; 1913:136-38; 1914:173-75; 1915:10-11).

16. One of the earliest sanitarian issues had been the connection between shipboard atmospheres (understood in terms of miasmatic theory) and the spread of disease (Frazer 1950:56).

17. Medical inspection concentrated on a small number of related eye diseases which involved the inflammation of the conjunctiva, the lining of the inner surface of the eyelid. These were: ophthalmia (the more general term), conjunctivitis (a mild form) and trachoma (a severe form).

18. The increased emphasis on mental handicap along with insanity in medical inspection seems to have paralleled a general change in public health, largely linked to the rise of eugenic theory. Mental handicap became an increasingly central issue in public health in this period (e.g. Sutherland 1976:73-6, Lewis 1982:150-1).

19. From the outset, medical authorities were allowed to deport after admission as one aspect of medical inspection. It was only in 1906, however, that it was spelled out clearly in legislation that immigrants who become public charges within two years had to be deported. After 1906, the number of deportations increased dramatically (Canada.Immigration 1919:19).

20. This tendency continued right through to the end of the period covered here. By 1919, 12,559 immigrants had been rejected at the border and 13,304 deported after settling in Canada since the introduction of medical inspection in 1903. Of those rejected, 86 per cent (10,614) were neither British nor American. Of those deported, 79 per cent (10,484) were either British or American.

21. Other critics of medical inspection on the grounds that too many people with mental disorders were admitted included: Sutherland (1915:168), Page (1915:560), Lee (1913:135).

22. The emphasis on the family structure underlay these arguments for exceptions in specific cases. For example, Bryce argued that it reflected positively on children that they should bring with them a senile parent:

> The cases of senility are those where old people may accompany their children, as Jacob went down to Egypt with his children, and are an evidence almost greater than any other of the moral status of the children who would thus care for aged parents (Canada.Interior 1914:177).

23. The word 'Canadianize' was used specifically by Clarke (1919:441) and by Bryce (in Canada.Interior 1915:28). It serves well to summarise a general perspective on the assimilation of immigrants that obtained in public health at the time.

24. This is discussed below in section 4.2.1.A on health visiting in Britain.

25. There is a tendency in the public health literature to include only non-English speaking immigrants when discussing the problems of immigrant adjustment. Shaver (1916:433) announced that he was deliberately focussing on non-anglophones. Laurie (1913) wrote specifically about the 'foreign' population, which in general use meant non-anglophones. Desloges (1919:2) explicitly excluded British-born immigrants from his discussion of 'the foreign-born' in asylums, despite the fact that his article was entitled 'Immigration'. He did state that British immigrants were also present in abnormal numbers, but did not attempt an explanation.

In short, there was a tendency in the public health literature to blur the boundary between the immigrant question and the 'foreign', i.e.non-anglophone (Desloges was alone in referring to Canada's 'two languages') question. There was a tendency to attribute the problematic aspects of immigration to non-anglophone immigrants.

26. The development of home visiting programmes in Canada is discussed below, section 4.3.1.A.

27. Bator (1979a:311) wrote that the department got rid of non-English language nurses in the 1920's on the grounds that "...they might encourage immigrants to resist assimilation into British Canadian society."

28. It was not only immigrant parents whom public health officials hoped to reach through their children. Lewis (1982:136) wrote:

> ...children were viewed as instruments and schools as agencies through which to educate parents to practice better nutrition and hygiene, better home management, and a 'higher' moral standard.

The assimilation of immigrants was seen as one the benefits of a general programme of elevation aimed at the working class. In the case of immigrants, the benefits of an approach through the children were particularly clear.

1. The concept of standardisation, coming from Pattin (1909) is introduced in Section 3.3.4 above. To recap briefly, it suggests a two-fold process of on the one hand the provision of standard minimal necessities of life and on the other of the establishment and enforcement of standards for work and home life.

2. There is a huge literature on this subject, to which I am unable to do justice here. Works discussing the contradictions of early twentieth century 'maternal feminism' and its links to social reform ideology consulted for this thesis included: Bacchi (1978), Roberts (1979), Kealey (1979), Ehrenreich and English (1979:164-70), Bland (1985) and Mort (1986).

3. A similar line of argument can be found in Heron (1906:278-81). He defined overcrowding and ignorance as the two major causes of the spread of tuberculosis. The solution for ignorance was obvious: "Of course, only in one way can we get rid of ignorance, and that is by educating the people." This could be achieved most effectively though home visits. The solution for overcrowding was more problematic: "...to get rid of overcrowding is one of the most troublesome problems of the day." No concrete steps were proposed.

4. Phthisis and consumption described forms of pulmonary tuberculosis. During the period examined here, the term tuberculosis tended to replace these others in the public health literature.

5. Kerr (1910:129) put a similar argument:

> The terribly heavy death-rate among young children in our towns is of course due to a certain extent to the relative unhealthiness of their surroundings, but that is by no means the chief cause. The factor that is of primary importance is maternal mismanagement.

6. For example, Crowley (1909:148), Dick (1904:883), Struthers (1914:68,70). The ICPD went so far as to imply that young men were less likely than women to fritter money away frivolously.

> Young men are said to take better care of themselves in this respect than the other sex, as they are not under the temptation to spend money in personal adornment, an object for which women will, it is said, stint themselves in food to a terrible degree, and sacrifice many other necessaries of life (ICPD 1904:41).

7. Poverty was increasingly conceived as a cycle, to be broken only at key strategic points:

> Poverty, uncleanliness, overcrowding, alcoholic indulgence and disease are closely inter-related in vicious circles, the starting point leading to infant mortality not always being the same (UK.LGB 1913b:89).

8. The Advisory Committee on Venereal Disease in Military District #2 was a committee formed to link campaigns oriented to civilians with the preventive campaigns based in the military. It played an important role in Canadian venereal disease work, and eventually served as the base for the formation of the national Canadian National Council for the Control of Venereal Diseases (Casselman 1981:177;212-3).

9. The related eugenic argument is discussed below. Public health works connecting the incarceration of the mentally handicapped and lack of restraint included Downey (1913:125), Clarke (1918:98) and Keys (1918:99-101).

10. Incarceration was also to isolate people seen as potentially threatening. Keys (1918:101) used a scare story about a mentally handicapped child to emphasize the potential danger to the public:

> Although but five years of age the child in question delights in hurting his baby step-sister by pricking her with pins and burning her with a hot poker. He has killed eight small rabbits, choked a cat by tying a string around its neck, and on two occasions set fire to the curtains in the house.

However, in this article as in many others, the prevention of biological reproduction is identified as the central reason for incarceration.

11. Eugenic theories were an important reason for the development of an interest in the regulation of sexuality in Britain as well as in Canada. One of the leading eugenists in British public health, Barr (1911:705) wrote:

> We are naturally concerned with the study of sexual subjects, which we are trying to raise from that disgraceful ribaldry and obscenity with which mankind has frequently treated this sacred function.

It was in 1911 that the Congress of the Royal Institute of Public Health first included a eugenics section in its annual congress. Eugenics gained official recognition at roughly the same time that overarching theories of regeneration (whether environmental or eugenic, material or idealist) were beginning to

be displaced by lower-order medicalised theories stressing the relationship between particular conditions and specific diseases.

12. A parallel could be drawn to the modern regulation of gay sexuality in Canada, in which activities between two consenting adults behind closed doors is considered private and beyond the realm of regulation, while various forms of open gay sexual expression are suppressed.

13. Discussed above in section 2.3.2.

14. Long (1907:737) traced the origin of women inspectors back to the appointment of women as workshop inspectors in Nottingham and London (Islington) in May and October 1892, to inspect workplaces where women were employed. The first woman sanitary inspector was appointed in Islington in 1895.

15. Equal pay for women inspectors seem to have been the exception rather than the rule. B. Gardiner of the Women Sanitary Inspectors Association, spoke to a meeting about the work of women sanitary inspectors:

> ...though it might differ in detail from that of the men sanitary inspectors, yet it was not generally regarded as inferior in either quantity or quality. Was there, therefore, any reason why, in almost every case, the salary of the woman sanitary inspector should be less than that of the man inspector? (in Richards 1907:196).

16. In 1909, Newsholme reported 174 health visitors and 55 female sanitary inspectors employed by English municipalities. This was before the tremendous explosion in the number of health visitors, which reached 600 in 1914, 812 in 1915 and over 1,000 in 1916. (U.K. LGB 1909:xxiv, 1915:xxxiv). It was health visiting, and not female sanitary inspection, which became the primary method associated with new legislation promoted against infant mortality.

Women sanitary inspectors qualified by passing the same Sanitary Institute exams as men (Dick 1904:879). As domestic hygiene diverged increasingly from orthodox sanitation, it is likely that this kind of training was seen as decreasingly relevant for home visiting.

Further, the whole image of inspection was incompatible with the sensitivities of the job. Kerr (1910:130) referred to the name "female inspector" as "a most inappropriate and unfortunate title." The title 'inspector' was much more likely to invite a defensive response from the women being 'visited'. The whole

question of the sensitivities of health visiting will be discussed below.

17. The Jewish Board of Governors developed a programme for the home care of tuberculosis patients. In it, patients first saw a doctor and then home visitors:

> The visitors then endeavoured to supervise the consumptive in his home and teach him the precautions he should take. Bottles and spittoons were provided, and it was insisted that they should be used; frequent visits were paid and they tries to prevent overcrowding (Josephs in Heron 1906:267).

The notification of tuberculosis began as voluntary notification at the local level. A few municipalities introduced experiments in compulsory notification. National legislation for compulsory notification was introduced in 1909, beginning with those treated in poor law institutions. In 1912, all cases were made notifiable (Gardiner 1904:888, UK.LGB 1909:xxi & 1913a:xxix)

18. Newsholme (1903:257) wrote, "...the curative aspect of sanatorium treatment is regarded as of secondary importance. We are chiefly concerned with educating these patients, and thus avoiding risk to others."

Narrowly, the patient was to be taught, "...to so manage his expectoration that it would no longer be a source of risk to his family and to those with whom he worked (ibid:256)." More generally, the patient could become an advocate of the sanatorium-style open air regime in everyday life (ibid:257 and Myers 1906:44).

19. The development of the category 'feeble-minded' was directly linked to this question of lack of moral self-control, particularly among women:

> Owing in part to a widespread desire for the more specialised treatment of cases of lesser mental defect, and more particularly for the better protection of girls and young women who were deficient in mind and self-control, the word 'feeble-minded' came into use as indicating a yet minor degree of defect than that implied by the words 'idiot' or 'imbecile' (UK.RCCFM 1908:155).

20. Venereal diseases could only be stamped out if people were taught a measure of self-control:

> The evils which lead to the spread of venereal diseases are, in great part, due to want of control, ignorance and inexperience, the importance of wisely conceived educational measures can hardly be exaggerated (UK.RCVD 1916:60).

21. This will be discussed below in the section on children. Physical education, for example, was pushed as a way of developing self-control:

> We may say that the effect upon the mind of class drilling is the cultivation of will, observation, discrimination, memory, and, above all, discipline (self-control), without which no character is complete (Sully 1905:30).

22. The increased emphasis on motherhood in the regulation of women's domestic labour is discussed in Davin (1978:12-16). This excellent article has been useful in many ways in the production of this thesis.

23. The demoralization created by poverty was clear in the description of life in one-room tenements in the ICPD (1904:17).

> ...persons usually of the lowest type, steeped in every king of degradation and cynically indifferent to the vile surroundings engendered by their filthy habits, and to the pollution of the young brought up in such an atmosphere.

24. Day care was not the only form of socialised housework considered by public health officials as an alternative for those women who had to work outside the home. O'Kell (1902:860-2), for example, called for special restaurants for women workers. She noted that the increasing number of restaurants in England was a sign that "...the bulk of the commercial and industrial population depend on such places for daily food." These did not meet the needs of working women due to low wages and long hours of work. She therefore called for the creation of special restaurants for women workers which offered substantial meals at suitable cost on a self-supporting basis. These were seen as necessary to save the moral health of single employed women living in a state of 'systematic semi-starvation.'

25. See UK.LGB (1909:xxiii & 234), Moore (1906:22), Dick (1904:883), Gardiner (1904:2), Richards (1907:154), all cited in section 4.2.1 above.

26. Moore (1906:21-4) B.Webb (1909:165) ICPD (1904:18,72) and Lyster (1910:195) all discuss the enforcement of parental responsibility.

27. Morant (1909:67)in his address to the Annual Dinner of the Society of MOHs "...noted with much interest that the Society had this year extended their borders to include the other sex." Farquharson (1902:165-700) called for the extension of the franchise to women to increase their capacity to press for sanitary reform, an area in which they had intrinsic skills and interests.

28. The creation of an alternative family tradition was a conscious goal. See for example ICPD (1904:42), cited p.226 above.

29. The concern about the transmission of pauperism between generations was a central one. Newman wrote that medical inspection aims to, "... stop the enrollment of child recruits in the army of the physically unfit, and thus diminish the burden which the maintenance of that army imposes on the nation (UK.Bd of Ed 1910:119).

30. The Boer war had provided a particularly important survey of the fighting physique of British men. The proportion of recruits rejected on the grounds of unfitness was regarded as a serious problem. The public discussion of this problem provided an important catalyst in the generalisation of family-oriented public health work from local initiatives to national programmes. (e.g. see ICPD 1904:v, Sadler in Sherrington 1903:27).

31. Anthropometric surveys were a favourite of the eugenics movement. These involve attempts to collect data through a range of measurements which quantified human characteristics. This data could be used as the basis for sociological generalisations regarding such questions as the improvement or degeneration of a specific race (over time); or for pseudo-scientific comparisons between races. The ICPD (1904:59) suggested that the medical inspection of school children would be a useful basis for an anthropometric survey. An article by Galton (1906), a leading eugenist, which called for broad anthropometric data collection in schools was printed in a prominent public health journal.

32. The argument that the educability of children depended on their physical health as determined by nutrition, cleanliness, medical treatment, etc. was a recurring one.

> ...unless some means are arranged by which the school child is ensured nourishment for the body, it is useless to provide food for the mind (Boulnois 1904:388).

Through this period, this logic came to be accepted in some form or another in the areas of inspection, treatment, school

meals and cleanliness. Despite the increasing realm of acceptable direct provision, these areas were clearly regarded as the exception. These were not the thin edge of the wedge of socialised child care, but rather the few areas in which parents' contributions could be channelled through the state, in essence made compulsory, and supplemented if necessary.

33. While the primary argument in Lyster's article was about parental responsibility, there was an important secondary one as well. Lyster seemed to be particularly concerned to protect the medical monopoly. He opposed school nursing on these grounds:

> The greatest of care should be taken to prevent any treatment being carried out by nurses, except under definite written instruction from a medical man, and the whole of their work should be under medical instruction and supervision (ibid:196).

Similarly, he opposed school clinics. This was in part due to a concern for parental responsibility (ensuring that those who could pay would), but also for the protection of doctors conditions. He noted that Bradford doctors had opposed the clinic there (ibid:197).

> If school clinics could be managed under ideal conditions which would include the exclusion of children whose parents are in a position to pay for treatment, and the adequate payment of the medical men engaged to do the work, there would be little to say against them...(ibid:198).

Lyster opposed treatment "under the control of educationalists (ibid:190)." If there was to be treatment, let it be universal and under medical control.

34. It is interesting how quickly school meals moved from being seen as a potential threat to a taken for granted service. New legislation in 1914 moved school meals out of the period Newman described as 'local experiments'. For the first time, central government grants were offered, meals were to be legally offered on school holidays, local 'ratecapping' for school meals was eliminated and the need for Board of Education sanction for school feeding was eliminated (UK. Bd of Ed 1913:241).

35. See UK.LGB (1913a:lv) and Cameron (1902:745) cited on p.243 above for references to oversight and supervision. See also UK.Bd of Ed (1912:337).

36. Neal (1917:45-6) discussed two reasons that tuberculosis nursing was generalised in Peterborough, Ontario: to eliminate

the stigma associated with a visit from a nurse specifically linked to tuberculosis control, and because the visits of tuberculosis turned up many other conditions which the nurse had to ignore.

37. Royce (1983:52) states that Eunice Dyke, the first head of public health nursing in Toronto, regarded families with working mothers as "strikingly abnormal." See also Conservation of Life (1919b:31)

38. The attitudes towards day care in Canadian public health were, of course, not uniform. Generally, however, I have not seen officials call for the establishment of day care or other services aimed at socializing a proportion of the domestic labour performed by working mothers. The closest I have seen is MacMurchy's (1910:16) recognition that creches and day nurseries could be useful, but "should be the very last resort." This could not be considered a call for creche services, following as it did a clear denunciation of such services:

> Institutions for infants, Creches, Day Nurseries, Infants Homes, are not at all the best solution for the problem of Infant Mortality among the poor, deserted and unfortunate...Nature spurns our false ideas of putting babies in institutions. Her one institution is the home... (ibid 15-16).

39. Lewis (1979a:311) wrote, "...children were viewed as the instruments and schools as agencies through which to educate parents to practice better nutrition and hygiene, better home management, and a 'higher' moral standard."

40. For example, Bacchi (1978?:466) wrote that Canadian suffragists supported the establishment of domestic science classes, linked to a general shift towards practical and technical education. See also Roberts (1912:182): "Such education must, above all things, be practical and useful."

41. Similar control was to be inculcated over other bodily functions. Struthers (1914:71) discussed the importance of regular nose blowing drills, to reduce, "...the very reprehensible habit of mouth breathing..."

42. Barr (1907:516) went further along the lines of discipline, writing:

> I would encourage the military spirit from early youth upwards, as the best means of developing the physique, and the moral and physical grit of the nation.

Appendix 1
Key Public Health Officials

This thesis has drawn heavily on the works of particular public health officials. These officials have been used much as 'key informants' are in participant observation. These particular officials were selected because they played crucial roles in establishing the standards of public health theory and practice in their day. They tended to write prolifically, to obtain important state positions at some point in their careers, and to be recognized by their peers in various ways.

These very brief biographies are provided to demonstrate the contribution of these officials. I have drawn particularly heavily on the works of George Newman and Arthur Newsholme in Britain, and of Peter Bryce, Helen MacMurchy and Lina Rogers Struthers in Canada.

United Kingdom

Newman, George

Newman was educated in London and Edinburgh. He qualified as a medical doctor in 1895. He began work as a lecturer in 1896 and a county medical officer in 1897. He began to work as well as MOH for Finsbury in 1900. It was in the latter role that he established himself as an authority on infant mortality.

This authority was clearly recognized when he was appointed as chief medical officer to the (national) Board of Education in 1907. In this position, he oversaw the introduction and expansion of the important public health programmes aimed at schoolchildren in Britain, particularly medical inspection, treatment and school meals. In 1919, Newman became the chief medical officer of the new Ministry of Health in Britain.

This thesis drew heavily on Newman's annual reports as well as a journal article. In general, he is noteworthy for his combination of vision and frank pragmatism. His role at the national level one involved the generalization of programmes both through pushing and cajoling the more backwards localities while attempting to restrain the most advanced.
(see: Dictionary of National Biography, 1941-50:624-5 and above sections 4.2.1.E and 4.2.2).

Newsholme, Arthur

Newsholme was of an earlier generation than Newman. He was educated in London, and qualified as a medical doctor in 1881. His public health responsibilities began with a posting as MOH of Clapham in 1884. He was appointed full-time MOH of Brighton four years later. He made notable contributions on school hygiene and tuberculosis prevention and treatment. In 1908 he was appointed as medical officer of the Local Government Board, a national

posting which was generally parallel to Newman's position at the Board of Education. In this position, he oversaw the generalisation of health visiting programmes through the country, and wrote special reports on infant mortality.

Newsholme retired when the Ministry of Health was introduced in 1919. Newsholme, perhaps more than Newman, envisioned a broad and encompassing state medicine. This was demonstrated, for example, in Newsholme (1935) in which he expresses tremendous admiration for Soviet state medicine. This thesis draws on Newsholme's annual reports at the L.G.B. as well as journal articles and books. (see Dictionary of National Biography 1941-50:625-6).

Canada

Bryce, Peter

Bryce was in many ways the founder of public health in Canada. He was educated in Toronto, Edinburgh and Paris (where he studied neurology under Charcot and others). He was appointed secretary to the Ontario Provincial Board of Health, the first permanent public health board in Canada in 1882. He remained at this position until 1904, when he took a position with the federal government as chief medical officer of the Department of the Interior. His responsibilities in this position included the introduction and development of the medical inspection of immigrants. According to McGinnis (1980:34-37) Bryce resigned after being overlooked for the position of Deputy Minister in the new Federal Department of Health after 1919.

Bryce was a prolific writer, whose interests ranged from political economy to tuberculosis prevention. A quick glance over the titles of his works in the bibliography gives a sense of his scope. His contribution was recognized by his peers through such honours as election to the presidency of the American Public Health Association in 1900 and Vice-Presidency of the American Congress of Tuberculosis in 1904. This thesis used both his numerous journal articles and his annual reports at the Ontario Provincial Board of Health and the Federal Department of the Interior (See Morgan 1912:164, Bator 1979a:33-35).

MacMurchy, Helen

MacMurchy was educated in Toronto and in Baltimore (at Johns Hopkins, a medical school which played a prominent role in the development of North American public health). She returned to Canada to begin medical practice. She was the founding editor of Canadian Nurse, a journal which among other things aimed to establish nursing as a profession. She was in charge of the medical inspection of girls in Toronto schools from 1910-11, a position which she left after battles (McGinnis 1980:119).

MacMurchy wrote two series of influential reports for the Ontario government. The first was a series of annual reports on

the condition of the mentally handicapped in Ontario, stemming from her position as 'Inspector of the Feebleminded'. The second consisted of three reports on infant mortality in Ontario commissioned by the Ontario Registrar-General. The formation of a federal Department of Health saw MacMurchy appointed as head of the Division of Child Welfare. For the purposes of this thesis I have used both series of reports for the Ontario government as well as some of her publications aimed at the general public. (see Morgan 1912:714 and Bator 1979:41-2).

Struthers, Lina Rogers

Struthers was educated as a nurse in Toronto and Montreal. She was the Superintendent responsible for the development of what became model school nursing programmes in New York City (beginning in 1902) and Toronto (after 1910) (see Sutherland 1981:373-377). This contribution was recognized when she went on to become the Chair of the National Organization for Public Health Nursing. Her book The School Nurse provides a thorough and thoughtful introduction to the process of home visiting and the balance between education and supervision. This book was particularly useful in the preparation of this thesis, together with the writings of her husband William Struthers who was the school Medical Inspector in Toronto.

List of Abbreviations

Canada.Interior	Canada. Department of the Interior
Canada.Immigration	Canada. Department of Immigration
ICPD	Interdepartmental Committee on Physical Deterioration (United Kingdom)
MOH	Medical Officer of Health
Ont.PBH	Ontario Provincial Board of Health
Ont.RCVD&FM	Ontario Royal Commission to Enquire into the Prevalence of Venereal Diseases and the Care of the Mentally Defective and Feeble-Minded
PH Editors	Public Health (journal, U.K.) editors
UK.Bd of Ed	United Kingdom. Board of Education
UK.Health	United Kingdom. Ministry of Health
UK.LGB	United Kingdom. Local Government Board
UK.RCAI	United Kingdom. Royal Commission on Alien Immigration
UK.RCCFM	United Kingdom. Royal Commission on the Care and Control of the Feeble-Minded
UK.RCVD	United Kingdom. Royal Commission on Venereal Disease
YMCA	Young Men's Christian Association

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